MINUTES OF THE SPECIAL STUDY COMMITTEE ON SOCIAL AND REHABILATIVE INSTITUTIONS

Held in Room 254-E at the Statehouse at 12:30 p.m., on February 4, 1980.

Members present were:

Senator Robert Talkington, Chairman
Representative Joe Hoagland, Vice Chairman
Senator Mike Johnston
Representative Phil Martin

Representative David Heinemann was excused.

Staff present were:

Emalene Correll, Legislative Research Department
Marlin Rein, Legislative Research Department
Ray Hauke, Legislative Research Department
Robert A. Coldsnow, Legislative Counsel

Conferees appearing before the committee were:

Secretary Robert C. Harder, Department of Social and Rehabilitation Services

The Chairman called the meeting to order.

As a continuation of materials and information furnished to members previously, Secretary Harder made available a copy of "Consolidated Standards for Child, Adolescent, and Adult Psychiatric, Alcoholism, and Drug Abuse Programs" (Attachment A) used in psychiatric facilities accreditation.

Secretary Harder also furnished copies of the "Governor's Task Force on SRS" (Attachment B) as mentioned by Senator Reilly at the January 31 meeting of this committee and also copies of a mid-December progress report on how the Department of SRS has responded to Task Force recommendations (Attachment C). Representative Hoagland asked the Secretary if the minutes taken during Task Force meetings and a list of conferees were available. He replied he would furnish the committee with a complete set of minutes.

Other information distributed by Secretary Harder included: a history of Topeka State Hospital, "On the Avenue of Approach" (Attachment D); an opinion from the Attorney General General (Attachment E) regarding criminal history record information; the Department's affirmative action plan (Attachment F); a sample of the kinds of work being done at institutions to protect human rights (Attachment G); and an example of the functions of a citizens' advisory committee as found in the minutes of the Community Advisory Committee to the Youth Center at Topeka (Attachment H).

In answer to questions, Secretary Harder stated he had updated and issued Secretary's Letters relating to inappropriate employee behavior, mandatory reporting of child or management abuse, and law enforcement

background procedures, all of which had been generally approved by the Attorney General. He added that all managers are expected to implement these Secretary's Letters which will become part of the overall training program for employees. He stated all managers must file with the Secretary a plan of implementation concerning their particular areas of responsibility. The Chairman requested copies of these plans and asked that they be made available to the committee as soon as possible. Secretary Harder stated members would have this information within a month. The Chairman asked if these plans of implementation would include recommendations made by the Task Force report. Secretary Harder replied they would respond to the Secretary's Letters only. He pointed out that one updated change in re-issued Secretary's Letters was that superintendents were to establish a citizens' advisory committee at each institution, and the Secretary noted information on the number of advisory committee meetings that have been held will be included in his February report to committee.

Mr. Coldsnow discussed with the committee future meetings and conferees. A copy of a letter from the superintendent at Osawatomie State Hospital stating his willingness to appear (Attachment I) was distributed. Mr. Coldsnow said that on February 7 persons from the Atchison area were scheduled to appear; on February 12, Johnson County conferees were tentatively scheduled; on February 13, conferees from Atchison and Osawatomie; and on February 14, additional conferees from Atchison were scheduled. Contacts have also been received from Topeka.

Mr. Coldsnow asked what action he should take relative to requesting Judge McKelvy, a probate and juvenile judge from Atchison, to appear. He was directed by the Chairman to contact the judge and review with him those items to which he would testify if necessary, and the committee would request that he appear.

Mr. Coldsnow asked if the committee wanted to set a policy as to how far back they wanted to hear about incidents at the various institutions for the purpose of this study. He pointed out some potential witnesses wanted to relate to matters occurring from two to sixteen years ago. Members were asked to consider this question for a decision at a later date.

The Chairman advised the committee a policy decision had been made that the committee will be holding its meetings in Topeka. He noted specific requests have been received for out-of-town meetings. He suggested that should these become necessary, consideration be given to the possibility of a subcommittee, to be officially recognized and approved by the Legislative Coordinating Council, being appointed, along with reduced staff, to fulfill these requests. He pointed out the committee or subcommittee could not be put in the position of having to go to all locations just because it had gone to one. Representative Hoagland felt no preliminary decisions on out-of-town interviews and meetings should be made until the committee has heard conferees who come to Topeka anyway.

Representative Martin pointed out members were getting reams of material relating to this study, and it was the concensus of opinion that some sort of index would be helpful.

Senator Johnston cautioned the staff of the narrow scope of the committee's charge and felt, in view of time limitations, persons interested in appearing should understand this. The Chairman stated this has been stressed, and the House Speaker and the Senate President have stated the charge to the committee as stated in minutes of the Legislative Coordinating Council is the exact intent of the Council.

The next meeting of the committee will be February 7, in Room 313-S, at 12:30 p.m.

The meeting adjourned at 1:00 p.m.

Robert V. Talkington

Chairman

ATTENDANCE SHEET
FEB. 4, 1980

NAME	REPRESENTING	TOWN
Dave Klotz	Assoc CMHCs KS	Topeka
Hal DeStardino	SRS	Topeka
Al Romer	SRS	"
C Smith	SRS	TOPEKA
K Skelton	SRS	Topeka
Wayne Sackman	Budget Div	"
[illegible]	Planning & Research	"
Robert Harden	SRS	"
Jack Bullock	me	"
Janet L. Small	Kansas Action for Children	Lawrence
Hamm		
Betty Stowers	MHAK	Topeka
Pat McKinley	Mental Health Assn in KS	Topeka
Rep. Cameron		

Attachment A

Consolidated Standards

for Child, Adolescent, and Adult Psychiatric, Alcoholism, and Drug Abuse Programs

1979 edition

Joint Commission
on Accreditation of Hospitals

Consolidated Standards

for Child, Adolescent, and Adult Psychiatric, Alcoholism, and Drug Abuse Programs

1979 edition

Joint Commission
on Accreditation of Hospitals

Foreword

In 1951, the American College of Physicians, the American Hospital Association, the American Medical Association, and the Canadian Medical Association joined with the American College of Surgeons to form the Joint Commission on Accreditation of Hospitals (JCAH) as an independent nonprofit organization for voluntary accreditation of hospitals. The Canadian Medical Association withdrew in 1959 to participate in its own national accreditation program, the Canadian Council on Hospital Accreditation.

By the mid-1960s, the demand for accreditation of facilities other than hospitals encouraged JCAH to expand. Through Memoranda of Agreement with 24 national organizations that represented particular categories of health and health-related services, JCAH established the Accreditation Council for Services for Mentally Retarded and Other Developmentally Disabled Persons, the Accreditation Council for Long Term Care Facilities, the Accreditation Council for Ambulatory Health Care, and the Accreditation Council for Psychiatric Facilities.

In the ensuing years each Council, under the auspices of JCAH, funneled its energies into maintaining accreditation programs, and establishing standards, survey procedures, and educational materials. During this period, the Accreditation Council for Psychiatric Facilities developed nationally-recognized accreditation programs and standards for adult psychiatric programs, child and adolescent psychiatric programs, alcoholism programs, drug abuse programs, and community mental health services.

In late 1978, to consolidate and strengthen the various accreditation programs, JCAH reorganized, dissolving the accreditation councils (as of June 30, 1979) and establishing a Professional and Technical Advisory Committee for each accreditation program and a Policy Advisory Committee to the Board of Commissioners.

For the next few years a major thrust of JCAH, while striving to provide the best possible services to the field, will be the integration and streamlining of many aspects of the survey process. This consolidation of all Accreditation Program for Psychiatric Facilities standards (with the exception of those for community mental health) represents one of the first steps in this effort.

John E. Affeldt, MD
President

Preface

To develop standards for psychiatric facilities, the Accreditation Council for Psychiatric Facilities was formed as part of the Joint Commission on Accreditation of Hospitals in 1970. As various accreditation programs within the Accreditation Council evolved—adult psychiatric, child and adolescent psychiatric, alcoholism, drug abuse, and community mental health—programs that provided more than one type of service experienced difficulty in reconciling the subtle differences that sometimes existed in each of the accreditation manuals. A careful review of the manuals revealed that, although similar in nature, language, and formating, the differences were substantial enough to cause confusion and hardship in the field. In addition, standards were developed in later accreditation manuals that were worthy of inclusion in those that had been published earlier.

JCAH and the Accreditation Council decided to consolidate the manuals, taking the most specific, concise, and measurable standards contained in each. The resulting manual would then be applicable to all child, adolescent, and adult psychiatric, alcoholism, and drug abuse programs. (Because revisions are being considered, standards for community mental health programs are not included in the consolidation.)

The *Consolidated Standards* are the product of input from Councillors who represented the various interest groups of the accreditation programs. In addition, hundreds of reviewers from many different types of programs throughout the United States have given extensive guidance and constructive criticism regarding format and the inclusion and applicability of certain standards. In keeping with JCAH's mission to promote optimal patient care, the *Consolidated Standards* outline the elements integral to the provision of high quality psychiatric, mental health, alcoholism, and drug abuse care.

Myrene McAninch, PhD
AP/PF Director
Richard D. Weedman, MSW
AP/PF Deputy Director

Contents

Using the Standards

Representing the integration of JCAH's adult, child and adolescent, alcoholism, and drug abuse manuals, the *Consolidated Standards* apply to a wide range of programs. The standards include the most specific, measurable, and rigorous quality of care and treatment criteria found in the manuals, with efforts made to reduce ambiguities of intent. All of the standards contained in this document apply to all programs, except as indicated in Appendix A, "Table of applicable standards" (see explanation below), and as indicated within the text of the standard (for example, Section 2.2.2.1 begins "In child and/or adolescent programs . . ." signaling that standard's applicability only to those types of programs).

The "General administrative policies and procedures" portion of these *Standards* describes the survey eligibility criteria and overall policies and procedures for survey application, survey, accreditation decision, and appeal; it should be reviewed carefully by those interested in seeking accreditation. Any questions should be directed, in writing, to the Accreditation Program for Psychiatric Facilities at JCAH's central office.

Appendix A, "Table of applicable standards," will assist a program in describing its operations and services and identifying applicable standards. The reader is advised to carefully review this appendix to avoid unnecessary and costly preparation for survey and/or failure to respond adequately to all necessary standards.

The major portion of this document is devoted to the standards, which have been clustered into four groups to assist the program in identifying and addressing issues critical to the quality of patient care. "Program management" covers such areas as governing body, clinical staff organization, personnel and administrative issues, and quality assurance; "Patient management" pertains to the implementation and documentation of direct intake, assessment, and treatment services; "Patient services" covers the various components of the service delivery system; and "Facility management" pertains to safety and sanitation, therapeutic environment, and infection control concerns. The "Glossary" should be consulted whenever questions about the intent of the standards or the language of the standards arise. It provides detailed explanations of many of the terms used and will aid in a precise understanding of the standards.

As important to a program as the surveyors' objective evaluation is a program's self-evaluation on the basis of JCAH standards. Since this document is used by surveyors as the survey document, it is ideal for use as a self-evaluation tool. Based on identification of the applicable standards using Appendix A, staff can easily rate a program's level of compliance with the standards. The compliance levels defined below should be used, placing the appropriate number on the line to the right of each standard.

1—Substantial compliance, indicating that the program's operations fully meet the intent of a standard as evidenced by action and documentation

2—Partial compliance, indicating that the program's operations address the intent of a standard but continued refinement and upgrading of procedures and/or documentation are needed before it achieves substantial compliance

3—Noncompliance, indicating that the program's operations do not meet the intent of a standard

4—Does not apply, indicating that a standard does not apply to the program

The overall compliance for each chapter should then be determined and placed in the appropriate space at the chapter's end. The "Summary of compliance" sheet found in Appendix D, "Surveyor materials," will provide an overall view of the program's level of compliance; and, as an added aid to the self-evaluation process, the program can complete the "Comments and recommendations" sections after each chapter, providing documentation to justify each rating.

Located in Appendix B of these *Standards* is a "Survey process questionnaire" that will provide the Accreditation Program for Psychiatric Facilities with a basis for evaluating the effectiveness of individual surveyors, information about areas that necessitate improved surveyor training techniques, and information on the effectiveness and efficiency of the entire survey process from the point of application through the summation conference. Programs are under no obligation to complete the questionnaire, but they are encouraged to do so as the answers will provide valuable information for improving JCAH's services to the field.

Appendix C, "Acknowledgements," credits those individuals who have contributed to these *Standards*, as well as those who have given of their time to JCAH and the Accreditation Program for Psychiatric Facilities. The contents of Appendix D, "Surveyor materials," have been included in these *Standards* for use by surveyors only, except for the aforementioned "Summary of compliance" sheet which can be used by a program for purposes of self-evaluation.

General administrative policies and procedures

Principles governing accreditation survey procedures

The purpose of an accreditation survey is to determine a program's extent of compliance with JCAH standards, which is assessed by using the following methods:

- statements from responsible program personnel;
- documentary evidence or certification of compliance with specific standards which is provided by the program;
- answers to surveyors' detailed questions, substantiated by visual observations and written documentation that verify compliance with specific standards; and
- on-site observations by surveyors.

Survey eligibility criteria

To be eligible for a survey by JCAH's Accreditation Program for Psychiatric Facilities (AP/PF), a program must meet the following criteria:

- be located within the United States or one of its territories or possessions; or be owned or controlled by the United States, an entity organized under the laws of the United States, or one of the states, territories, or possessions;
- have been in operation and actively caring for patients for at least six months prior to its application;
- maintain facilities, beds, and/or services that are available to individuals and their families over a continuous 24-hour period, seven days a week and/or that are available over a less than 24-hour a day period on a regulary scheduled basis;
- be in compliance with the applicable federal, state, and local laws and regulations, including any requirements for licensure;
- have a governing body and organized clinical staff whose primary function is the diagnosis, treatment, and/or rehabilitation of persons evidencing psychiatric, mental health, alcoholism, and/or drug abuse problems;
- provide the information requested by AP/PF; and
- operate without discrimination by reason of race, creed, color, sex, or national origin.

Application for survey

Requests for an application for survey should be addressed to the Accreditation Program for Psychiatric Facilities, Joint Commission on Accreditation of Hospitals, 875 North Michigan Avenue, Chicago, Illinois 60611.

In the application for survey, the program will indicate all categories of service that it offers and that JCAH accredits. Programs offering two or more such categories of service shall seek accreditation for all of them (see "Multiple-category facilities" below).

Except where prohibited by law, a nonrefundable processing fee must be included with the application for survey.

Survey fees and schedules

The survey of a program will be conducted by AP/PF survey personnel. The composition of the survey team will be determined according to the size, structure, and level of complexity of the program; and the number of days required for the survey will be determined by AP/PF. The organization will be notified of the survey date(s) approximately four weeks in advance. The invoice for payment will be sent to the program prior to the survey date and, except where prohibited by law, must be paid in full in advance. The survey fees will be related to the survey's actual cost, as determined annually by JCAH.

If the program cancels its survey in writing more than four weeks prior to the survey date, the survey fee less the deposit will be refunded. If a program cancels its survey in writing less than four weeks before the survey date, JCAH reserves the right to retain any direct costs incurred in the preparation of the survey.

Multiple-category facilities

For the purpose of JCAH accreditation, a multiple-category facility is defined as a program offering two or more categories of service for which JCAH offers accreditation under differing standards. When seeking accreditation, such a program must apply to JCAH for survey of all these categories of service. Additional application and survey fees may be charged when more than one category of service is to be surveyed. Programs that provide more than one category of service falling under the purview of AP/PF will be surveyed under the *Consolidated Standards* and will receive a single accreditation decision. JCAH no longer considers such programs to be multiple-category facilities.

For multiple-category facilities seeking accreditation, the Department of Integrated Surveys of JCAH will determine the composition of the survey team, the duration of the survey, and the standards and survey procedures that are applicable to each category of service. Efforts will be made to conduct a single, integrated survey to assure that the accreditation process is the most convenient and economical for a program. Accreditation decisions will be made independently for each category surveyed. To retain any JCAH accreditation, however, a program must apply at least annually for survey of each service category that is not accredited or is accredited for one year. The determination to survey or to defer survey shall be the prerogative of JCAH.

Public information interviews

JCAH will provide an opportunity during the surveyors' on-site visit for the presentation of information by representatives of consumers, the public, and the staff of the program undergoing survey. Anyone wishing to present information regarding the program's conformance to JCAH standards may request a public information interview. The program must post on its premises, in a public place, the official JCAH notice of the survey date and of the opportunity for such an interview. The public notice must be posted approximately four weeks prior to the survey and must remain posted until the first day of the survey. All requests for a public information interview must be received in writing by JCAH two weeks prior to the survey. Although the program need not publicize survey information in the mass media, it is expected to share with anyone, upon request, the date(s) of the survey and the fact that a public information interview may be requested or that such an interview has already been scheduled. To assure that the public information interview policy has been carried out properly, AP/PF surveyors are required to obtain a copy of the public notice at the time of survey.

Public information interviews are usually conducted during the first morning of the survey and normally do not exceed two hours in length. The program is expected to provide reasonable accommodations, and program personnel are expected to attend. AP/PF surveyors will conduct the interview session and receive all relevant information. The interview will consist only of the orderly receipt, within the prescribed time limit, of verbal and written information. All information received by this method will be fully considered for pertinence and accuracy, and the findings included in the surveyors' report. Any further participation in the survey by an outside source must be authorized by the program.

Confidentiality

All information obtained by JCAH during the accreditation survey process, including information obtained during the public information interview and the contents of the surveyors' report, is considered confidential. Except as required by law, JCAH will not release any information obtained through the survey of any program without that program's written authorization. The contents of the AP/PF report will be provided only to the participating program and may be disseminated solely at its discretion.

JCAH will, however, provide the following information to anyone upon request:

- whether or not an application for survey has been received from a program for either an initial survey or resurvey;
- a list of programs scheduled for survey in any or all states for the current quarter of the calendar year, without enumeration of specific survey dates;
- upcoming survey dates for a program, after the program has been notified;
- the current accreditation status of a program, after the program has been so notified, including any preliminary adverse actions for which the program has the right to appeal or which the program is in the process of appealing; and
- the accreditation history of a program.

Accreditation decision and duration of accreditation

At the completion of the on-site visit, the surveyors will conduct a summation conference with representatives of the governing body, administration, and clinical staff. At this time, the surveyors will present the survey findings for discussion and clarification, with full opportunity for the exchange of information or rebuttal to any adverse findings.

AP/PF staff will review the report and recommendations of the surveyor, and any other relevant information, and make an accreditation recommendation to the Accreditation Committee of the Board of Commissioners. Individuals from the Professional and Technical Advisory Committee for Psychiatric Facilities are nonvoting members of this committee.

The Accreditation Committee will make an accreditation decision based on the survey documents and AP/PF's recommendation. No member of the Accreditation Committee who is in any way affiliated with a program will participate in deliberation or vote on the accreditation status for that program.

With the single exception for fire safety problems noted below, programs will be granted two-year accreditation, one-year accreditation, or nonaccreditation. JCAH will notify the program of the accreditation decision and provide specific recommendations for correction of noted deficiencies as they relate to the standards. Copies of these reports will be forwarded to the program's chief executive officer and the heads of the governing body and clinical staff.

For programs that are constructing or renovating and exhibit only fire safety problems at the time of survey, a two-year decision may be rendered with the proviso that the program's efforts to achieve full compliance are demonstrated during a one-day survey to be conducted, at the program's expense, within nine months after the award of such accreditation. The exact time period within which the one-day survey must be conducted will be determined by the Accreditation Committee when making the accreditation decision. However, if at the time of the one-day survey substantial effort to comply with the fire safety standards is not demonstrated, accreditation may be reduced to one year or be revoked by JCAH.

A program not granted accreditation, or whose accreditation is withdrawn, is eligible to apply for another survey no earlier than six months following the final decision not to accredit. This six-month waiting period may be waived by the president of JCAH when the program demonstrates sufficient progress in correcting deficiencies to justify such a waiver and presents evidence indicating hardship as a result of the adverse decision. JCAH reserves the right to survey an accredited program at its discretion.

Accreditation is not transferable. JCAH must be advised immediately when an accredited program changes ownership or control, or undergoes a major change in its capacity or in the categories of service offered, with disclosure of all factors involved in the change. If JCAH decides that a new survey is necessary, the program must submit an application for survey and the required fee within 20 days of such notification by JCAH. Failure to comply with these procedures will result in a loss of accreditation.

JCAH must also be notified immediately of the merger of any program with another. If the merging programs are both accredited, then the merged program must be surveyed within one year of such notification. A merger with a program not accredited by JCAH requires completion of a new ap-

plication for survey and a survey of the merged program. For purposes of accreditation, a merged program has a single governing body, single administrator, and single clinical staff.

Accreditation is not automatically renewable at the end of an accreditation period. The program must submit an application for survey; a new survey will be conducted and new accreditation decision rendered.

Appeal of nonaccreditation decisions

A program not granted accreditation, or whose accreditation is withdrawn is entitled to an appeal in accordance with JCAH's appeal procedures. The program will receive an outline of the appeal procedures when notified of the nonaccreditation decision. If a program chooses to appeal the decision, the first step is an interview with an AP/PF representative or representatives, which gives the program an opportunity to demonstrate that it was not in less than full compliance with the standards at the time of the survey. Within 20 days of its receipt of the notification of nonaccreditation, the program must advise AP/PF of its desire for such an interview. The previous accreditation of the program will be retained until the appeal is abandoned by the program or a final decision is made. When the appeal is abandoned, the nonaccreditation decision becomes final as of that date. A final decision to deny accreditation by JCAH becomes effective on the date of decision.

Public recognition

A program will receive a JCAH certificate of accreditation when awarded accreditation status. The certificate will specify the name of the program and the year in which accreditation is granted.

The initial certificate, as well as a new certificate reflecting a name change, will be provided without charge. Additional certificates are available from JCAH at the cost of reproduction.

The certificate and all copies remain the property of JCAH and must be returned to JCAH if a new certificate reflecting a name change is issued or if accreditation is withdrawn for any cause.

Standards

Program management

1. Governing body

1.1 Every program shall have a governing body that has the ultimate authority for the overall operation of the program. _____

1.1.1 If the governing body is a public organization, it shall provide a written description of the administrative organization of the government agency within which it operates. _____

1.1.1.1 A written description of the lines of authority within the government agency in relation to the governing body of the program shall also be provided. _____

1.1.2 If the governing body is a private, nongovernmental organization, it shall provide written documentation of its source of authority through charter, constitution and bylaws, and, where required, state license. _____

1.2 The program's ownership and controlling parties, including the names and addresses of all owners or controlling persons, shall be fully disclosed. _____

1.2.1 This full disclosure of owners and controllers is required whether they be individuals; partnerships; corporate bodies; or subdivisions of other bodies, such as public agencies or religious, fraternal, or other charitable organizations. _____

1.2.2 In the case of corporations, the name and addresses of officers, directors, and principal stockholders, either beneficial or of record, shall be disclosed. _____

1.3 Accreditation status is not transferable on change of ownership or control. The accredited program shall advise JCAH within 30 days of any such change. Accreditation, at the discretion of JCAH, may be continued provisionally until JCAH can make an appropriate determination of the status of the program under the new ownership or control. _____

1.4 The governing body shall hold meetings at least quarterly. _____

1.4.1 Minutes shall be kept of these meetings and shall include, but need not be limited to, the following items:

a. date of the meeting; _____

b. names of members attending; _____

c. topics discussed; _____

d. decisions reached and actions taken; _____

e. target dates for implementation of recommendations; and _____

f. chief executive officer or other reports. _____

1.5 The governing body shall develop a committee structure to fulfill its responsibilities and to assess the results of the program's activities. _____

1.5.1 The governing body, through its chief executive officer, shall have a written statement of the program's goals and objectives, as well as written procedures for implementing these goals and objectives. _____

1.5.1.1 Documentation shall verify that this statement is based upon a planning process that is approved by the governing body. _____

1.5.2 The governing body, through its chief executive officer, shall have a written plan for obtaining financial resources that are consonant with the program's goals and objectives. _____

1.6 The governing body shall actively participate in the accreditation process; and one or more governing body members shall be in attendance at the time of survey and during the final summation conference. _____

1.7 When a specific categorical program (e.g., adult, child and adolescent, alcoholism, and/or drug abuse) is a component of a larger program, it shall have sufficient planning, leadership, organizational, and operational authority to meet its special needs. _____

1.7.1 The specific categorical program shall have sufficient authority for the acquisition and development of an adequate number of staff with qualifications and/or training appropriate to their work, and shall have authority for the hiring and/or placement of any staff. _____

1.8 The governing body, through its chief executive officer, shall develop policies and shall have or make available sufficient resources, e.g., funds, staff, equipment, supplies, and facilities, designed to assure that the program is capable of providing appropriate and adequate services to patients. _____

1.9 The program shall have insurance to protect its physical and financial resources. The buildings and equipment should be appropriately covered, and members of the governing body and appropriate administrative and clinical personnel should have adequate comprehensive liability insurance. _____

1.10 The governing body shall establish bylaws, rules and regulations, and/or a table of organization for relationships among itself, the responsible administrative and clinical staffs, and the community. _____

1.10.1 There may be one set of bylaws or rules and regulations which clearly delineates the responsibilities and authority of all members of the governing body and the administrative and clinical staffs. _____

1.10.2 There may also be separate bylaws, guidelines, or rules and regulations adopted by the administrative and/or clinical staff consistent with the policies established by the governing body.

1.10.3 The bylaws, guidelines, or rules and regulations shall be in accordance with legal requirements, shall strive to assure the high quality of patient care, and shall be consonant with the program's community responsibility.

1.10.3.1 Such regulations shall include a definition of the powers and duties of the governing body, its officers, and its committees; or such regulations shall describe, if such is the case, any legally designated person's authority and responsibilities, as well as the authority and responsibility delegated to the responsible administrative and clinical staffs.

1.10.3.2 Such regulations shall state the eligibility criteria for governing body membership; the types of membership and the method of selection of members; the method for determination of a quorum and the attendance requirements for governing body meetings; and the length of the terms of appointment or election for governing body members, officers, and committee chairpersons.

1.10.3.3 Such regulations shall describe the qualifications, authority, and responsibilities of the chief executive officer.

1.10.3.4 Such regulations shall specify the manner of appointment of the chief executive officer.

1.10.3.5 Such regulations shall provide that staff have sufficient autonomy and freedom to carry out their responsibilities within the framework of the organization of the program.

1.10.3.6 Such regulations shall provide sufficient authority to enable the clinical staff to provide high quality patient care.

1.10.3.7 Such regulations shall state the regulations under which the administrative and clinical staffs function.

1.10.3.8 Such regulations shall require that controls be established that are designed to assure that each professional member of the staff observes all the standards of the profession and assumes and carries out clinical and/or administrative functions in a manner consistent with local, state, and federal laws and regulations.

1.10.3.9 Such regulations shall delineate the organizational structure of the staff and describe the method of selection of members, duties, functions, responsibilities, and composition of any staff standing committees.

1.10.3.10 Such regulations shall specify the method for performing credentials review.

1.10.3.11 Such regulations shall specify procedures for admission to and retention of staff membership, including the delineation and assignment of administrative and/or clinical authority and responsibilities.

1.10.3.12 Such regulations shall provide for a procedure for the granting or denial of staff appointments and reappointments, as well as for the granting, denial, curtailment, suspension, or revocation of clinical and administrative authority and responsibilities. _____

1.10.3.12.1 Unless otherwise provided by law, this procedure shall provide that the staff have the right to be heard at some step of the process. _____

1.10.3.12.2 The final decision shall be rendered by the governing body within a fixed period of time. _____

1.10.3.13 Such regulations shall provide procedures for the selection of staff officers, directors, and department or service chiefs. _____

1.10.3.14 Such regulations shall require that the evaluation and authentication of medical histories, the performance and recording of physical examinations, and the prescribing of medications be carried out by physicians with appropriate qualifications, licenses, and clinical privileges. _____

1.10.3.14.1 Dentists with appropriate qualifications, licenses, and clinical privileges also shall prescribe medications. _____

1.10.3.15 Such regulations shall establish requirements regarding the frequency of and staff attendance at general and department, service, team, or unit meetings. _____

1.10.3.16 Such regulations shall delineate the clinical privileges of all clinical staff as well as the responsibilities of the physician members of the staff in relation to nonmedical clinical staff. _____

1.10.3.17 Such regulations shall include provisions for a mechanism by which the administrative and clinical staffs report to the governing body. _____

1.10.3.18 Such regulations shall include an effective, formal means by which the administrative and clinical staffs may participate in the development of program policies relative to both program management and patient care. _____

1.10.3.19 Such regulations shall establish an orientation program for new governing body members and develop a continuing education program for all members of the governing body. _____

1.10.3.20 Such regulations shall provide that the bylaws, guidelines, or rules and regulations be reviewed at least every two years, revised as necessary, and signed and dated to indicate the time of last review. _____

Overall compliance: governing body _____

Comments and recommendations
Provide specific documentation for each 2 or 3 rating.

_____

_____

2. Chief executive officer

2.1 The governing body shall appoint a chief executive officer whose qualifications, authority, and duties shall be defined in the governing body's bylaws and/or rules and regulations.

2.1.1 In programs where, in lieu of a single chief executive officer, more than one person has direct executive authority granted by the governing body and direct responsibility to the governing body, those persons shall comply with all of the standards contained herein relating to the chief executive officer.

2.2 The chief executive officer shall be a health professional.

2.2.1 The chief executive officer should have a medical degree or a master's degree in administration, psychology, social work, education, or nursing, with appropriate licenses when required.

2.2.1.1 Carefully evaluated experience, when justified and documented by the governing body, may be substituted for a professional degree.

2.2.2 The chief executive officer shall have appropriate professional qualifications and experience, including administrative responsibility in a health facility.

2.2.2.1 In child and/or adolescent programs, the chief executive officer shall have appropriate professional qualifications and experience, including administrative responsibility in a facility for children and/or adolescents.

2.3 In accordance with the program's bylaws and/or rules and regulations, the chief executive officer shall be responsible to the governing body for the overall operation of the program, including the control, utilization, and conservation of the physical and financial assets of the program and the recruitment and direction of staff.

2.4 The chief executive officer shall assist the governing body in formulating policy. The chief executive officer shall prepare for, present to, and review with the governing body the following items:

a. long-term and short-term plans;
b. reports on the nature and extent of funding and other available resources;
c. reports describing the program's operations;
d. evaluation reports dealing with the efficiency and effectiveness of the program; and
e. budgets and financial statements.

2.5 The chief executive officer shall ensure that a written manual defining program policies and procedures is prepared, regularly revised, and updated. The manual shall contain all of the written policies and procedures required by these *Standards*. _____

2.6 Documentation shall verify that the chief executive officer attends and participates in continuing education programs. _____

Overall compliance: chief executive officer _____

Comments and recommendations
Provide specific documentation for each 2 or 3 rating.

3. Clinical staff organization

3.1 The governing body shall hold the clinical staff responsible for making recommendations to it concerning staff appointments, reappointments, and privileges.

3.2 The appointment and reappointment of clinical staff members shall be based upon well-defined, written criteria which are related to the goals and objectives of the program, as set forth in the bylaws and/or rules and regulations of the governing body and/or clinical staff.

3.2.1 The governing body shall utilize the advice of the clinical staff in defining the scope of clinical privileges and in granting them to individuals, commensurate with their qualifications, experience, and present capabilities.

3.2.2 No applicant shall be denied clinical staff membership and/or clinical privileges on the basis of age, sex, race, handicap, creed, color, or national origin.

3.2.3 Applicants for clinical staff membership and/or clinical privileges shall sign an agreement to abide by the governing body and/or clinical staff bylaws and/or rules and regulations.

3.2.4 The governing body shall inform applicants of the disposition of their application for clinical staff membership and/or clinical privileges within a reasonable period of time after their applications have been submitted.

3.3 The governing body shall require that the clinical staff establish controls that are designed to ensure the achievement and maintenance of high standards of professional ethical practice.

3.3.1 The governing body shall establish policies stating that only members of the clinical staff and clinical practitioners granted temporary staff privileges shall admit patients to the program.

3.3.2 A physician member of the clinical staff shall be responsible for the care of any medical problem that may arise during inpatient or residential treatment.

3.4 When required, members of the clinical staff shall be licensed.

3.4.1 Both physician and dentist staff members shall be fully licensed to practice in the state in which the program is located.

3.5 Clinical privileges granted to dentists shall be based on their training, experience, and demonstrated competence and judgment.

3.5.1 The extent of surgical procedures that each dentist may perform shall be specifically defined.

3.6 Each member of the clinical staff shall assume responsibility for abiding by clinical staff and program policies.

3.6.1 A major responsibility in this context is that of appropriately documenting a patient's disabilities and the treatment rendered.

3.6.2 Beyond this requirement, a member of the clinical staff shall take an active role in the development of policies and standards of patient care through the mechanisms of the clinical staff organization.

3.7 The clinical staff shall have rules and regulations that establish a means of carrying out its responsibility to the governing body.

3.7.1 There shall be a mechanism for, and evidence of, a periodic review and revision, as necessary, of the rules and regulations.

3.7.1.1 The rules and regulations shall define the qualifications, functions, and responsibilities of the clinical staff.

3.7.1.2 The rules and regulations shall delineate the organizational structure of the clinical staff.

3.7.1.3 The rules and regulations shall specify the qualifications and procedures for admission to, and retention of, staff membership, including the delineation, assignment, reduction, or withdrawal of privileges.

3.7.1.4 The rules and regulations shall specify the method of performing credentials review.

3.7.1.5 The rules and regulations shall provide a procedure relative to clinical staff recommendations for denial of staff appointments and reappointments, as well as for denial, curtailment, suspension, or revocation of clinical privileges.

3.7.1.5.1 This procedure shall provide that a practitioner have the right to be heard, upon request, at some step of the process.

3.7.1.5.2 The final decision shall be made by the governing body within a fixed period of time.

3.7.1.6 The rules and regulations shall provide methods for the selection of officers and department or service chairpersons.

3.7.1.7 The rules and regulations shall specify composition and functions of standing committees as required by the complexity of the program.

3.7.1.8 The rules and regulations shall establish requirements regarding the frequency of, and attendance at, general and department or service meetings of the clinical staff.

3.7.1.9 The rules and regulations shall require that the evaluation and authentication of mental health and medical histories, the performance and recording of physical examinations, and the prescribing of treatment be carried out by those with appropriate licenses and clinical privileges.

3.7.1.10 The rules and regulations shall establish requirements regarding completion of patient records. _____

3.7.1.11 The rules and regulations shall provide for a mechanism by which the clinical staff consults with, and reports to, the governing body. _____

Overall compliance: clinical staff organization _____

Comments and recommendations

Provide specific documentation for each 2 or 3 rating.

4. Staff composition

4.1 To adequately evaluate and meet the fundamental needs of patients, all programs shall have available a sufficient number of appropriately qualified clinical, administrative, and support staff.

4.1.1 The clinical staff shall have qualified personnel involved when indicated in physical health services, mental health services, nursing, education, occupational therapy, recreation, counseling, speech, hearing, pharmacy, anesthesia, clinical testing, and pathology laboratories.

4.2 The program shall have a written plan which clearly delineates the number and qualifications of its clinical, administrative, and support personnel as determined by at least the following:

a. the size of the program;

b. the clinical characteristics of the patient population;

c. the fundamental needs of the patients;

d. the characteristics of the program's patients, e.g., adults, children, adolescents, or those with alcohol or drug problems;

e. the hours and days the program operates; and

f. all applicable federal, state, and local laws and regulations.

4.2.1 When appropriate qualified clinical staff members are not available or not needed on a full-time basis, arrangements shall be made to obtain sufficient services on an attending, continuing consultative, or part-time basis.

4.2.2 Inpatient programs shall have on duty, at all times, a registered nurse to plan, assign, supervise and evaluate nursing care, and to assure that patients receive the nursing care that requires the judgment and skill of a registered nurse.

4.2.3 Annual documentation shall verify that clinical staff meet all federal, state, and local requirements for licensing, registration, and/or certification.

4.3 The clinical staff shall participate in determining the qualifications (e.g., training, experience, and documented competence) required for assuming specific clinical service responsibilities.

4.3.1 There shall be a written plan delineating the supervision of all clinical activities by qualified, experienced personnel.

4.3.2 The assignment of clinical responsibilities to members of the treatment team and/or trainees shall be in accordance with the policies contained in the program's procedures manual and with Section 11.7.2.2 of these *Standards.* _____

Overall compliance: staff composition _____

Comments and recommendations
Provide specific documentation for each 2 or 3 rating.

5. Personnel policies

5.1 Personnel policies and procedures shall be designed, established, and maintained to promote the objectives of the program and to ensure that an adequate number of qualified personnel is provided, during all hours of operation, to support a high quality of care and the functions of the program. _____

5.1.1 All policies shall be written, systematically reviewed, and approved on an annual basis by the governing body and dated to indicate the time of last review. _____

5.1.2 The policies shall include procedures for the recruitment, selection, promotion, and termination of staff. _____

5.1.3 Policies specific to the chief executive officer and service directors shall be defined. _____

5.2 The personnel policies and procedures shall be available and apply to all employees and shall be discussed with all new employees. A mechanism shall be established for notifying employees of changes in the policies and procedures. _____

5.2.1 Documentation shall verify that the written personnel policies and procedures are explained and given to each employee and are available to others upon request. _____

5.2.2 Included in the written policies and procedures shall be information on the following:

a. employee benefits; _____
b. recruitment; _____
c. promotion orientation; _____
d. training and staff development; _____
e. employee grievances; _____
f. safety and employee injuries; _____
g. relationships with employee organizations; _____
h. disciplinary systems; _____
i. suspension and termination mechanisms; _____
j. wages, hours, and salary administration; _____
k. rules of conduct; _____
l. lines of authority; _____
m. performance appraisals; and _____
n. equal employment opportunity and, when required, affirmative action policies. _____

5.2.3 The written personnel policies and procedures shall describe methods and procedures for the supervision of all personnel, including volunteers. _____

5.2.4 The written policies and procedures shall include a mechanism for determining that all personnel are medically and emotionally capable of performing assigned tasks and are free of communicable and infectious diseases. _____

5.3 There shall be a written statement of the policies and procedures for handling cases of patient neglect and abuse. The written statement shall be given to all personnel and be available to others who have authority, as determined by the governing body, to request the statement. _____

5.3.1 Any alleged violations of the statement shall be investigated and the results of such investigation shall be reviewed and approved by the governing body. _____

5.4 A staff member shall be appointed by the chief executive officer to implement and coordinate the personnel policies and procedures and to accomplish the following tasks:

a. develop a written organizational plan for personnel services; _____
b. maintain personnel records; _____
c. disseminate general employment information to staff; _____
d. undertake staff orientation program development; _____
e. implement procedures to ensure compliance with federal, state, and local laws related to employment practices; and _____
f. supervise the processing of employment-related forms. _____

5.4.1 A personnel record shall be kept on each staff member and shall contain the following items, as appropriate:

a. the application for employment; _____
b. references by letter and a record of verbal references; _____
c. verification of all training and experience, and licensure, certification, registration, and/or renewals; _____
d. wage and salary information, including all adjustments; _____
e. performance appraisals; _____
f. initial and subsequent health clearances; _____
g. counseling actions; _____
h. disciplinary actions; _____
i. actions of commendation; and _____
j. employee incident reports. _____

5.4.1.1 There shall be written policies and procedures that are designed to ensure the confidentiality of personnel records and define who has access to various types of personnel information. _____

5.5 Hiring practices shall be consistent with the needs of the program. _____

5.5.1 Selection of personnel shall be based upon criteria that are demonstrably related to the job under consideration. _____

5.5.1.1 The therapeutic characteristics of a program may lead to the development of a staff reflective of the specific patient popula-

tion served. Personnel policies, however, shall comply with all federal, state, and local regulations dealing with fair employment practices.

5.5.1.2 Programs shall not arbitrarily refuse employment to individuals with known personal drug and alcohol abuse, mental illness, or criminal histories.

5.5.1.3 Provisions shall be made for personnel who speak languages other than English, when there is substantive utilization of the program by a language minority, and for personnel familiar with special languages for the blind and deaf as appropriate.

5.6 There shall be a written job description for each position in the program which includes a specific statement of duties and responsibilities and the minimum level of education and training and/or related work experience required or needed to fulfill them. Each job description shall specifically identify the following items:

a. position title;
b. department, service, or unit;
c. direct supervisor's title;
d. position supervised;
e. degree of supervision;
f. tasks and responsibilities of the job;
g. career ladder; and
h. location of the job, and materials and equipment used, if any.

5.6.1 Written job descriptions shall be sufficiently detailed to accomplish the following:

a. clearly describe job functions;
b. delineate clinical, administrative, and procedural responsibility and authority;
c. serve as a basis for performance appraisals; and
d. allow another or new person to assume functions when necessary.

5.6.1.1 Job descriptions shall accurately reflect the actual job situation and shall be revised whenever a change is made in the required qualifications, duties, supervision, or any other major job-related factor.

5.7 Performance appraisals shall be developed according to the job performed and related to the written job description. The criteria by which the job performance of staff members is evaluated during the appraisal should be valid, reliable, and objective.

5.7.1 Performance appraisals shall be conducted during the initial employment relationship and annually.

5.7.2 Performance appraisals shall be in writing.

5.7.2.1 Documentation shall verify that the employee has reviewed the evaluation and had an opportunity to comment upon it. The employee shall be asked to sign the appraisal after review and comments are completed.

5.7.3 When it is found that a serious gap exists between the staff member's actual job performance and the criteria for optimal job performance, the staff member shall be informed of the skills, knowledge, or attitudes expected and should be encouraged to perform the job according to these optimal levels of job performance. Appropriate training programs should be considered. _____

5.7.3.1 Appropriate subsequent performance appraisals should be completed. _____

5.8 Any wages paid to patients engaged in vocational training or work within the program shall be in accord with the applicable local, state, and federal requirements. _____

5.9 Annually, the personnel service shall prepare a written statistical report concerning its functions. _____

Overall compliance: personnel policies _____

Comments and recommendations

Provide specific documentation for each 2 or 3 rating.

6. Volunteer services

6.1 When volunteers are utilized, an appropriately qualified and experienced staff member shall be assigned to select and evaluate volunteers and coordinate volunteer activities.

6.2 The objectives and scope of the service and the authority and responsibilities of the volunteer coordinator shall be clearly stated in writing, and shall be reviewed at least annually and signed and dated by the chief executive officer or a designee.

6.2.1 The volunteer coordinator shall perform the following functions:

a. assist the staff in determining the need for volunteer services and in developing assignments;

b. plan and implement the program for recruitment of volunteers;

c. coordinate the recruitment, selection, and training of volunteers, and the referral of volunteers for placement in appropriate services or units;

d. inform staff as to proper, effective, and creative use of volunteers;

e. work to increase the readiness of salaried staff to effectively utilize volunteers;

f. keep the staff and community informed about volunteer services and activities;

g. provide opportunities for volunteers to acquire the qualifications for certification, when applicable; and

h. provide or assign an appropriate staff member to provide ongoing supervision, inservice training, and evaluation of volunteers.

6.3 An orientation program shall familiarize all volunteers with the goals and services of the program and provide appropriate clinical orientation regarding the program's patients.

6.3.1 The orientation program shall include explanations of at least the following:

a. the importance of confidentiality and the protection of patients' rights;

b. how to respond to and follow the procedures for unusual events and incidents; and

c. the program's channels of communication and the differences between administrative and clinical authority and responsibility.

6.4 Volunteers shall be under the direct supervision of the staff of the service or unit utilizing their services, receiving general direction and guidance from the volunteer coordinator.

6.5 Utilization of volunteers as members of treatment teams to supplement the total treatment program shall be done only in collaboration with appropriate members of the clinical staff and with consideration of the patients' needs for continuity. _____

6.5.1 The supervisory clinical staff shall be available to provide guidelines for volunteers that will enhance volunteer-patient interactions and make the most effective use of this unique relationship. _____

6.5.2 Communication practices shall be designed to assure that observations by volunteers are reported to the clinical staff responsible for the patient. These observations may be entered in the patient's record. _____

6.5.3 In addition to performing other services for the program, volunteers may be utilized to help meet the patients' basic needs for social interaction, self-esteem, and self-fulfillment. _____

6.6 The records and reports of volunteer activities shall contain information useful in evaluating the effectiveness of the volunteer service. _____

6.6.1 At least the following records shall be maintained by the volunteer service:

a. a personnel record for each volunteer which includes the application, record of assignments, and progress reports; _____

b. a master assignment schedule for all volunteers, including times and units of assignment; and _____

c. a current job description for each volunteer. _____

Overall compliance: volunteer services _____

Comments and recommendations

Provide specific documentation for each 2 or 3 rating.

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7. Fiscal management

7.1 Each year, the program shall have a formal, written budget of expected revenues and expenses. _____

7.1.1 The written budget shall categorize revenues for the program by source. _____

7.1.2 The written budget shall categorize expenses by the types of services and/or program components provided. _____

7.1.3 The written budget shall be reviewed annually and approved by the governing body prior to the beginning of the next fiscal year of operation. _____

7.1.4 Revisions of the budget during the fiscal year of operation shall be reviewed and approved by the governing body. _____

7.2 The fiscal management system shall include a fee schedule. _____

7.2.1 The program shall maintain a current written schedule of rate and charge policies that has been approved by the governing body. _____

7.2.1.1 The fee schedule shall be accessible to all program personnel and all individuals served by the program. _____

7.3 The fiscal management system shall maintain a reporting mechanism that provides information regarding the fiscal performance of the program. _____

7.3.1 Reports shall be provided that show the relationship of the budget to actual experience, including revenues and expenses by category and explanations of reasons for variances. _____

7.3.2 Reports developed by the financial reporting system shall be available to those staff and governing body members who participate in budget preparation and have fiscal management responsibilities. _____

7.4 An audit of the financial operations of the program shall be performed by an independent public accountant at least annually. _____

7.4.1 For government programs, this audit shall be performed in accordance with the regulations promulgated by the responsible government agency. _____

7.4.2 Documentation shall verify that the reports of such audits have been reviewed and approved by the governing body. _____

7.5 Current written policies and procedures shall be maintained regarding the operation of the fiscal management system. _____

7.5.1 There shall be written policies and procedures for the control of inventories, including purchasing authority and procedures, product selection and evaluation, and supply storage and distribution. _____

7.5.2 There shall be written policies and procedures for the control of accounts receivable; for handling cash; for credit arrangements; and for discounts, write-offs, and billings. _____

7.5.3 Records shall be maintained to document compliance with these established policies and procedures. _____

Overall compliance: fiscal management _____

Comments and recommendations
Provide specific documentation for each 2 or 3 rating.

8. Referrals

8.1 The program shall have written referral policies and procedures that facilitate patient referral and consultation between the program's components and/or between the program and other service providers in the community. _____

8.1.1 The written policies and procedures shall delineate the conditions under which referrals and consultations are made. _____

8.1.1.1 The conditions under which referrals and consultations are made shall include a need for the following items:

a. examinations, assessments, or consultations that are not within the professional domain or expertise of the staff; _____

b. special treatment services; and _____

c. the assistance of other providers that can contribute to the patient's well-being. _____

8.1.2 The written policies and procedures shall describe the methods by which continuity of care is assured for the patient. _____

8.1.2.1 These methods shall include, but not be limited to, providing the receiving component or other community service provider with the following information:

a. background information related to the referral; _____

b. treatment-related patient data, e.g., current treatment, diagnostic assessments, and special requirements; _____

c. treatment objectives desired; _____

d. suggestions for continued coordination between the two resources; _____

e. special clinical management requirements; and _____

f. the mechanism by which the patient can be returned to the referring program or program component. _____

8.1.2.2 These methods shall include requesting a follow-up report from the receiving resource within a designated time period. _____

8.1.3 The written policies and procedures shall describe the mechanism by which a patient may request referral to another component or community service provider. _____

8.1.4 The written policies and procedures shall describe the means by which the program assists in the referral of those individuals who are seeking services that the program does not provide. _____

8.1.5 The annual review and approval of the referral policies and procedures by the chief executive officer and appropriate administrative and clinical staff shall be documented. _____

8.2 Each program component shall keep a current, confidential log of all referrals that it initiates and receives. _____

8.3 Each community service provider to which patients are referred shall express in writing its willingness to abide by federal, state, program, and JCAH standards dealing with the confidentiality of patient information. _____

8.3.1 When community service providers are used repeatedly, a letter of agreement and/or contract shall be developed. _____

Overall compliance: referrals _____

Comments and recommendations
Provide specific documentation for each 2 or 3 rating.

9. Research

9.1 When a program conducts or participates in research with human subjects, there shall be written policies designed to assure that rigorous review is made of the merits of each research project and of the potential effects of the research procedures on the participants.

9.2 There shall be an interdisciplinary research review committee made up of individuals qualified by training and experience to conduct reviews of research projects. This committee may be either a permanent standing committee or a committee convened on an as-needed basis and composed of individuals with appropriate experience in the research area to be reviewed.

9.2.1 A majority of the members of the review committee should be made up of individuals who are not directly associated with the research project under consideration. Some members should be selected from among individuals not formally associated with the program.

9.2.2 Prior to the authorization and beginning of each research project, the research committee shall conduct a detailed review of the project. This initial review shall form the basis for the written report that shall be submitted by the committee to the chief executive officer. This review shall be concerned with:

a. the adequacy of the research design;

b. the qualifications of the individuals responsible for coordinating the project;

c. the benefits of the research in general;

d. the benefits and risks to the participants;

e. the benefits the program will derive from the research;

f. the possible disruptive effects of the project on program operations;

g. the compliance of the research design with accepted ethical standards;

h. the process to be used in obtaining informed consent from participants; and

i. the procedures for dealing with any potentially harmful effects that may occur in the course of the research activities.

9.3 All individuals asked to participate in a research project shall be given the following information prior to being asked to give their consent:

a. a description of alternative services that might prove equally as advantageous to them;

b. a full explanation of the procedures to be followed, especially those that are experimental in nature;

c. a description of the potential discomforts and risks; and

d. a description of the benefits to be expected.

9.3.1 If the investigator does not wish to fully disclose to the participants the purpose, nature, outcome, and implications of the research prior to its commencement, the investigator shall clearly and rigorously justify to the review committee that such disclosure is inadvisable and that failure to give full disclosure is not detrimental to the participants. Under such conditions, disclosure may be deferred until the research project is completed.

9.4 All research project participants shall sign a consent form which indicates their willingness to participate in the project.

9.4.1 The consent form shall address all of the information contained in Section 9.3 and shall indicate the date the form was signed and the name of the person who supplied the participant with the information.

9.4.1.1 The participant's right to privacy and confidentiality shall be addressed by the informed consent document.

9.4.1.2 Neither the consent form nor any other written or oral agreement entered into by the participant shall include any language through which the program, its agents, or those responsible for conducting the research are released from liability for negligence.

9.4.2 All prospective participants over the age of 12 and all parents of participants under the age of 18 shall sign a written consent form that indicates willingness to participate in the project.

9.4.2.1 The consent form shall contain the full information described in Section 9.3, as well as the date the consent form was signed and the name of the individual who supplied the prospective participant with the information.

9.4.3 Prospective participants age 12 or younger and all prospective participants who are legally or functionally incompetent to provide informed consent shall participate only when and if consent has been given by a person legally empowered to consent and such consent has been reviewed by an independent advocacy group, if available.

9.4.3.1 Such legal guardian and/or advocate shall receive the same information as required in Section 9.3 and shall sign the consent form.

9.5 The denial of consent to participate by any potential research subject shall not be a cause for denying or altering the indicated services to that patient.

9.6 Participants shall be allowed to withdraw consent and discontinue participation in the project at any time without affecting their status in the program.

9.7 Privacy and confidentiality should be strictly maintained at all times.

9.8 Upon completion of the research procedures, the principal investigator shall attempt to remove any confusion, misinformation, stress, physical discomfort, or other harmful consequences that may arise in the participants as a result of the procedures.

9.8.1 Investigators and others directly involved in research shall adhere to the ethical standards of their respective professions concerning the conduct of research and should be guided by the regulations of the Department of Health, Education, and Welfare on the protection of human subjects (Title 45, Part 46, 1978). _____

9.9 Upon completion of the research, the principal investigator, whether a member of the program staff or an outside researcher, shall be responsible for communicating to the staff of the program, in a manner which they can understand, the purpose, nature, outcome, and possible practical or theoretical implications of the research. _____

9.10 Reports of all research projects shall be maintained by the program. _____

Overall compliance: research _____

Comments and recommendations

Provide specific documentation for each 2 or 3 rating.

10. Patient rights

10.1 Programs shall support and protect the fundamental human, civil, constitutional, and statutory rights of the individual patient. _____

10.2 There shall be a written plan or policies and procedures that describe the patients' rights and the means by which these rights are protected and exercised. These rights shall include the following. _____

10.2.1 Access to treatment shall be impartial, that is, free of discrimination by race, religion, sex, ethnicity, age, or handicap. _____

10.2.2 Care and treatment shall, at all times, recognize and respect the personal dignity of the patient. _____

10.2.3 The patient has a right to individualized treatment, which shall include at least the following:

a. adequate and humane services, regardless of source(s) of financial support; _____

b. least restrictive environment; _____

c. an individual treatment plan; _____

d. active participation of the patient over 12 years of age and of the responsible parent, relative, or guardian in the planning for treatment; _____

e. periodic review of the treatment plan; and _____

f. an adequate number of competent, qualified, and experienced clinical staff supervising and implementing the treatment plan. _____

10.2.4 The program's environment and procedures shall assure and protect the personal privacy of the patient within the constraints of the individual treatment plan. _____

10.2.4.1 Program policies shall allow patient visitation by all members of the patient's family and significant others, regardless of the visitor's age, unless clinically contraindicated. _____

10.2.4.2 Suitable areas shall be provided for patients to visit in private, unless this is in conflict with the patient's treatment plan. _____

10.2.4.3 Patients shall send and receive mail without hindrance. _____

10.2.4.4 Patients shall be allowed to conduct private telephone conversations with family and friends, unless clinically contraindicated. _____

10.2.4.5 If therapeutic indications necessitate restrictions on visitation, telephone calls, or other communications, those restrictions shall be evaluated for continuing therapeutic effectiveness at least every seven days by the clinically responsible staff. _____

10.2.4.6 If limitations on visitations, calls, or other communications are indicated by practical reasons, e.g., expense of travel or phone calls, such limitations shall be determined with the participation of the patient and family. All such restrictions shall be fully explained to the patient and the family. _____

10.2.5 The patient has the right to request the opinion of a consultant at personal expense or to request an in-house review of the individual treatment plan as provided in the specific procedures of the program. _____

10.3 The patient shall be informed of his or her rights in language understood by the patient. _____

10.3.1 The patient shall receive a written description of the patient rights, and such a description shall be posted in various areas of the program. _____

10.4 Each patient over the age of 12 shall be fully informed about the following items:

a. his or her rights; _____
b. the clinical staff responsible for his or her care and those staff members' professional status and staff relationship; _____
c. the nature of the care, procedures, and treatment which he or she will receive; _____
d. the present and future use and disposition of products of special observation and audiovisual techniques such as one-way vision mirrors, tape recorders, television, movies, or photographs; _____
e. the risks, side effects, and benefits of all medications and treatment procedures used, especially when the medications and treatment procedures are unusual or experimental; _____
f. his or her participation in any research project that introduces additional inconvenience or risk (see the "Research" section of these *Standards*); _____
g. the alternative treatment procedures that are available; _____
h. the right to refuse to participate in any research project without compromising access to the program's services; _____
i. the right, to the extent permitted by law, to refuse specific medications or treatment procedures; _____
j. the program's responsibilities, when he or she refuses treatment, to seek appropriate legal alternatives or orders of involuntary treatment, or, in accordance with professional standards, to terminate the relationship with him or her upon reasonable notice; _____
k. the cost, itemized when possible, of services rendered to him or her; _____
l. the source of the program's reimbursement, and any limitations placed on duration of services; _____
m. any proposed change, and the reasons for such change, in the clinical staff responsible for him or her, or any transfer of him or her within or outside of the program; _____

n. the rules and regulations of the program applicable to his or her conduct; _____

o. the right to initiate a complaint or grievance procedure and the appropriate means of requesting a hearing or review of the complaint; _____

p. the discharge plans; and _____

q. the plans for meeting continuing mental and physical health requirements following discharge. _____

10.4.1 In all cases dealing with child and adolescent patients, the responsible parent, relative, or guardian shall also be informed about these items. _____

10.5 Each patient over the age of 12 shall give written, dated, and signed informed consent to the following:

a. voluntary admission to the program; _____

b. the release of confidential information; _____

c. the use of audiovisual equipment; _____

d. the utilization of surgical procedures; _____

e. the utilization of electroconvulsive therapy; _____

f. the utilization of any unusual medication or hazardous assessment or treatment procedure; _____

g. participation in any research project; _____

h. transfer to another facility; _____

i. discharge plans; and _____

j. aftercare plans. _____

10.5.1 In all cases dealing with child and adolescent patients, the responsible parent, relative, or guardian shall also give written, dated, and signed informed consent to these items. _____

10.6 The confidentiality of communications between patients and staff and of all information recorded in the patient record shall be the responsibility of all staff (see the "Patient records" section of these *Standards*). _____

10.6.1 The program shall have continuing training for all staff and specific orientation for all new personnel in the principles of confidentiality and privacy. _____

10.7 A patient shall be allowed to work for the service provider only under the following conditions:

a. the work is part of the individual treatment plan; _____

b. the work is performed voluntarily, with full consent of the patient; _____

c. the patient receives wages commensurate with the economic value of the work; and _____

d. the work is in accordance with local, state, and federal laws and regulations. _____

10.7.1 A patient may be required to perform tasks of a personal housekeeping nature without compensation. _____

10.8 Unusual or experimental drugs, treatments, or procedures shall be reviewed by the research review committee, or other appropriate peer review committees, prior to utilization. _____

10.9 When a program uses physical restraints or seclusion as a part of its therapeutic procedures, an explicit written statement of policies and procedures, as described by the "Treatment plans" section of these *Standards*, shall be reviewed and approved annually by the chief executive officer and the clinical staff. _____

10.9.1 Physical restraints or seclusion may be used only as a therapeutic measure to prevent the patient from causing physical harm to self or others, or to prevent serious disruption of the therapeutic environment. _____

10.9.2 Physical restraints or seclusion may not be used as a punishment, as discipline, as a convenience for the staff, or as a mechanism to produce regression. _____

10.9.3 Physical restraints or seclusion may be used only in accordance with these *Standards* and the provisions of local, state, and federal laws and regulations. _____

10.9.4 The physical space utilized for seclusion shall be immediately accessible to staff for observation and care of the patient and shall adequately accommodate the patient's physical and environmental needs without undue violation of personal dignity. _____

Overall compliance: patient rights _____

Comments and recommendations
Provide specific documentation for each 2 or 3 rating.

11. Quality assurance

11.1 To identify problems in the delivery of care, the program shall implement quality assurance activities. _____

11.1.1 The quality assurance activities shall include, but are not limited to, the following:

a. program evaluation procedures; _____

b. evaluation of clinical privileges; _____

c. professional growth and development activities; _____

d. utilization reviews; _____

e. individual case reviews; and _____

f. patient care audits. _____

11.2 There shall be a written plan describing the mechanisms for assuring the comprehensive integration of quality assurance activities. _____

11.2.1 All clinical disciplines reflected in the composition of the clinical staff and all members of the treatment team shall be included in the quality assurance activities in a reasonably representative manner. _____

Program evaluation

11.3 The program shall have a written statement of goals and objectives. _____

11.3.1 The program's goals and objectives shall be based upon a planning process. _____

11.3.2 The goals and objectives shall be related to the needs of the population to be served. _____

11.3.3 The goals and objectives shall specify the services to be provided or shall specify other means by which these goals and objectives can be attained. _____

11.3.4 The goals and objectives shall be updated at least annually. _____

11.3.5 A written statement of the goals and objectives shall be provided to the governing body and program management and shall be available to program staff. _____

11.4 There shall be a written plan for evaluating the program's level of attainment of its goals and objectives. _____

11.4.1 The plan shall specify information and data to be collected, and methods of retrieval and analysis of such data.

11.4.2 The plan shall specify methods for assessing the utilization of staff and other program resources in terms of the goals and objectives.

11.4.3 The plan shall specify the timetable for the evaluation, which shall be carried out at least annually.

11.4.4 The plan shall specify the criteria to be used in assessing the level of attainment of the goals and objectives.

11.4.5 The plan shall require that failure to achieve goals and objectives be explained.

11.5 Documentation shall verify the following items:

a. the goals and objectives were written and are revised at least annually;

b. the goals and objectives were provided to the governing body and program management and were made available to program staff;

c. the evaluation plan was conducted; and

d. the results of the evaluation were provided to the governing body and program management and were made available to program staff.

11.6 Written evidence shall verify that the findings of the evaluation have influenced program planning.

Clinical privileges

11.7 There shall be a written plan describing the methods by which the clinical staff defines the qualifications required to provide clinical services in the program.

11.7.1 The written plan shall delineate the clinical authority and responsibilities of the clinical staff and be in accordance with the standards regarding clinical staff rules and regulations contained in the "Clinical staff organization" section of these *Standards.*

11.7.2 Members of the clinical staff shall be licensed, when required, to exercise the clinical privileges granted to them.

11.7.2.1 The qualifications and clinical privileges shall comply with all applicable federal, state, and local laws, rules, and regulations.

11.7.2.2 All members of the treatment team who have been assigned specific treatment responsibilities shall have training or experience and demonstrated competence, or shall be supervised by clinical staff members who are qualified by experience to supervise such treatment.

11.7.2.3 When physicians are members of a program's clinical staff, the relationship between physician and nonphysician members of the clinical staff shall be clearly delineated.

11.7.3 Documentation shall verify that the determination of clinical privileges has been influenced by the findings of the quality assurance program.

Professional growth and development

11.8 Appropriate programs of staff development for administrative, clinical, and support personnel shall be provided.

11.8.1 Staff development shall be under the supervision and direction of a committee or qualified person. Such person or committee may delegate any part of the responsibility for the program to appropriately qualified individuals.

11.8.2 Documentation shall verify participation in such programs.

11.9 Evidence shall verify that the clinical staff is provided with a continuous program of professional education which is designed to keep the staff informed of significant new clinical and administrative developments and skills.

11.9.1 The clinical staff development program should include intramural activities.

11.9.1.1 Such activities shall be planned and scheduled in advance and should be held on a continuing basis.

11.9.2 The program's continuing education programs should make use of educational opportunities outside the program, such as workshops, institutes, seminars, and formal continuing education courses.

11.9.3 These programs shall be designed to meet the needs identified in the quality assurance program.

11.9.4 The program shall communicate and collaborate, as appropriate, with national and local mental health professional and standards-setting organizations in the planning and providing of continuing education programs.

11.10 The results of patient care audit studies shall be an important part of the staff development programs.

11.10.1 Documentation shall verify that the clinical staff has reviewed the clinical work of its members.

11.10.2 Written evidence shall verify that staff development activities are influenced by the findings of the quality assurance program.

11.11 The staff development programs shall reflect all administrative and service changes in the program and shall contribute toward the preparation of personnel for greater responsibility and promotions.

11.12 A mechanism for evaluating the effectiveness of professional education and inservice training programs at least annually shall be provided.

11.12.1 All such evaluations shall be both signed and dated by the reviewer(s).

11.13 Appropriate orientation and training programs shall be available for all employees.

11.13.1 These programs shall be held prior to, or at least on, the day that employment begins.

11.13.2 The programs for new employees shall include event-training or incident-training when appropriate, and shall familiarize each employee with the existing staff backup and support system.

11.14 Each service group shall maintain regular communication meetings among the people responsible for training.

11.14.1 Such communication shall help to coordinate training procedures and define effective and efficient training plans.

11.14.2 Evaluations of the effectiveness of the training program should be made in collaboration with appropriate national standards-setting organizations.

Utilization review

11.15 The program shall demonstrate appropriate allocation of its resources through the conduct of a utilization review program.

11.15.1 In keeping with the program's striving to provide optimal achievable quality of patient care in the most cost effective manner, the utilization review program shall make every effort to assure appropriate allocation of the program's resources.

11.15.1.1 The utilization review program shall address underutilization and inefficient scheduling, as well as overutilization, of the program's resources.

11.16 The program shall implement a written plan that describes the utilization review program and governs its operations. This plan shall be approved by the clinical staff, the administration, and the governing body, and shall include at least the following:

a. a delineation of the responsibilities and authority of those involved in the performance of utilization review activities, including members of the clinical staff, any utilization review committee(s), the administration, and, when applicable, any qualified outside organization contracting to perform review activities;

b. a conflict of interest policy, applicable to all those involved in utilization review activities;

c. a confidentiality policy, applicable to all utilization review activities and resultant findings and recommendations;

d. a description of the method(s) for identifying utilization-related problems;

e. the procedures for conducting concurrent review; and

f. a mechanism for initiation of discharge planning.

11.16.1 The methods for identifying utilization-related problems shall include analyses of the appropriateness and clinical necessity of admission, continued stays, supportive services, and delays in the provision of supportive services, as well as utilization of the findings of related quality assurance activities and other current relevant documentation.

11.16.1.1 Such related activities may include, but are not limited to, profile analyses, the results of retrospective patient care evaluation studies, medication usage reviews, infection control activities, and reimbursement agency utilization reports that are component/service specific.

11.16.1.2 Retrospective monitoring of the program's utilization of resources shall be ongoing to identify problems and document the impact of corrective actions taken.

11.16.2 The procedures for conducting concurrent review shall include the time period within which the review is to be initiated following admission, and the length-of-stay norms and percentiles to be used in assigning continued stay review dates.

11.16.2.1 The determination of which patients are to be reviewed concurrently shall not be based solely on source of payment.

11.16.2.2 Written measurable criteria and length-of-stay norms that have been approved by the clinical staff shall be utilized in performing concurrent review and shall be included in or appended to the program's utilization review plan.

11.16.2.3 Length-of-stay norms must be specific to diagnoses, problems, and/or procedures.

11.16.3 Discharge planning shall be initiated as early as a determination of the need for such activity can be made to facilitate discharge as soon as care is no longer required.

11.16.3.1 Criteria for initiating discharge planning may be developed to identify those patients whose diagnoses, problems, or psychosocial circumstances usually require discharge planning.

11.16.3.2 The discharge planning activity shall not be limited to placement in long-term care facilities but also shall include provision for, or referral to, services that the patient may require to improve or maintain his or her mental health status.

11.17 The program's utilization review program, including the written plan, criteria, and length-of-stay norms, shall be reviewed and evaluated at least annually, and revised as appropriate to reflect the findings of the program's utilization review activities.

11.17.1 A record shall be maintained of such reviews, and the findings shall be reported to the appropriate committee of the clinical staff and to the governing body.

Individual case review

11.18 Each program shall have a written plan designed to ensure that the clinical care planned and provided for patients is evaluated and updated according to the needs of each individual patient. _____

11.19 Individual case review meetings shall be held in all services, departments, units, or teams, and shall be documented. _____

11.19.1 Individual case reviews shall be conducted on a random basis at regular intervals and shall include a review of the following:

a. unresolved diagnosis problems; _____
b. unimproved patients; _____
c. diagnostic errors; _____
d. treatment failures; _____
e. complications in treatment; and _____
f. other treatment issues. _____

11.19.2 An essential feature of the individual case review is the supervisory and consultative roles of other clinical staff to the provider of services. The supervisory and consultative responsibility between staff members shall be reflected and documented in one or more of the following places:

a. the individual patient record; _____
b. minutes of staff meetings and conferences; _____
c. schedules maintained for individual and group supervision of all clinical staff; _____
d. minutes of individual case review meetings; and _____
e. notes of supervisory sessions or clinical consultation. _____

Patient care audit

11.20 The program shall have a written plan for evaluating the quality of patient care services which shall include at least the following. _____

11.20.1 The quality of services shall be evaluated by members of the staff directly responsible for providing services. _____

11.20.1.1 This may be conducted by evaluation as a service treatment unit or delegation of the responsibility to a committee. _____

11.20.1.2 The committee membership shall be representative of the staff responsible for providing services. _____

11.20.2 The quality of services shall be determined by measuring the actual services against specific criteria. _____

11.20.2.1 These criteria shall be established or adapted by the staff for the evaluation of all services provided. _____

11.20.2.2 The criteria shall be explicit and measurable, and shall reflect the optimal level of service that can be achieved in light of current psychiatric, mental health, alcoholism, and/or drug abuse knowledge.

11.20.2.3 The criteria shall be such that outcomes of intervention can be analyzed, therapeutic processes can be justified, and complications resulting from therapeutic and administrative procedures can be identified.

11.20.2.4 The criteria may be in terms of specific goals described in individual treatment plans.

11.20.2.5 The criteria shall be revised or updated to reflect the findings of previous studies, improvements in techniques, and scientific advances.

11.21 The patient record, the primary source of information for patient care audits, shall be accurate and complete.

11.21.1 In an effort to ensure that evaluation measures are unbiased, the number of patient records used in the evaluation study shall be representative of the services being provided by all staff.

11.21.2 The method used for retrieving, abstracting, and reporting data from patient records shall be efficient and designed to ensure the reliability of the data.

11.22 Variations from the established criteria shall be identified.

11.22.1 Identified variations shall be justified by the staff evaluating patient care based upon information prerecorded in the patient record.

11.22.2 The staff evaluating the quality of services shall explicitly document justified variations.

11.22.3 Variations that are not justified to peer satisfaction must be analyzed by the staff evaluating patient care services.

11.22.4 If analysis indicates inappropriate patterns of service, action must be taken to correct problems.

11.22.4.1 Corrective actions should be specific to the problems and may include educational or training programs, amended policies and procedures, increased or realigned staffing, provision of new equipment or facilities, adjustments in staff privileges, and/or increased supervision.

11.23 Corrective actions shall be validated by completed follow-up studies.

11.23.1 Follow-up studies of corrective actions for problems posing a threat to health or safety shall be undertaken immediately and continued until it is clearly demonstrated that the problem has been corrected.

11.23.2 Follow-up studies for problems identified as an indication of less than optimal services, but not immediately threatening to patients, shall be completed within a reasonable period of time.

11.23.2.1 The time span for follow-up studies shall be defined by the staff responsible for the evaluation of the quality of services.

11.24 The entire patient care evaluation process shall be documented. _____

11.24.1 The general findings of, and specific recommendations from, evaluation studies must be reported to, at least, the individual with overall responsibility for the program's treatment services, the chief executive officer, and the governing body. _____

11.25 Evaluations of the quality of services shall be continuous, comprehensive with respect to the conditions and problems treated, and inclusive of the procedures performed. _____

11.25.1 The evaluations of the quality of services shall be either ongoing or repeated periodically, according to the criticality of the evaluation study topic and the problems identified. _____

11.26 The results of evaluations shall be reflected in other quality assurance functions, including reappointment and reprivileging of staff members, control and utilization of organizational resources, the continued monitoring of staff and therapeutic activities, and the provision of continuing staff development and training. _____

Overall compliance: quality assurance _____

Comments and recommendations
Provide specific documentation for each 2 or 3 rating.

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Program evaluation

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Clinical privileges

Professional growth and development

Utilization review

Individual case review

Patient care audit

12. Patient records

12.1 A written patient record shall be maintained for each patient. _____

12.1.1 The patient record shall describe the individual's status at the time of admission, the services provided, the progress made, and the status at the time of discharge. _____

12.1.2 The patient record shall serve as a basis for treatment planning, coordination, and implementation. _____

12.1.3 The patient record shall provide a means of communication among all appropriate staff who are involved in the patient's treatment. _____

12.1.4 The patient record shall substantiate the adequacy of the assessment process as the basis for the treatment plan. _____

12.1.5 The patient record shall facilitate continuity of treatment, as well as facilitate the determination, at a future date, of the patient's condition and what treatment was being provided at any specified time. _____

12.1.6 The patient record shall furnish documentation of observations of the patient's behavior, ordered and supervised treatment, and responses to treatment. _____

12.1.7 The patient record shall provide information for the review, study, and evaluation of the treatment provided to the patient. _____

12.1.8 The patient record shall provide data, when appropriate, for use in training, research, evaluation, and quality assurance measures. _____

12.1.9 The patient record shall provide documentation of the protection of the rights of the patient, the patient's family, the program, and the staff. _____

12.1.10 The patient record shall provide documentation of the involvement of the patient, parents, siblings, or other family members in the patient's treatment program. _____

12.1.10.1 A separate record for each family member may need to be maintained. _____

12.2 The patient record shall contain all pertinent information. _____

12.2.1 The patient record shall contain identifying data, including the following items:

a. name; _____

b. home address; _____

c. home telephone number; _____

d. date of birth; _____
e. sex; _____
f. race or ethnic origin; _____
g. next of kin; _____
h. education; _____
i. marital status; _____
j. type and place of employment; _____
k. date of initial contact or admission to the program; _____
l. legal status, including relevant legal documents; _____
m. other identifying data as indicated; _____
n. date the information was gathered; and _____
o. signature of staff member gathering the information. _____

12.2.2 The patient record shall contain the source of referral. _____

12.2.3 The patient record shall contain the reason for referral (i.e., presenting problems or complaints). _____

12.2.4 The patient record shall contain a record of the completed assessment of the patient. _____

12.2.5 The patient record shall contain a record of the initial formulation and diagnosis based on the assessment of the patient. _____

12.2.6 The patient record shall contain a record of the individual treatment plan, and revisions thereof, prepared in accordance with the "Treatment plans" section of these *Standards*. _____

12.2.7 The patient record shall contain a record of all medications administered including type, dosage, adverse reactions, errors, frequency of administration, physician or dentist prescription, and person who administered each dose. _____

12.2.7.1 Medication administration shall be in accordance with the "Pharmacy services" section of these *Standards*. _____

12.2.8 The patient record shall contain information on any unusual events or occurrences such as the following:

a. treatment complications; _____
b. accidents or injuries to the patient; _____
c. morbidity; _____
d. death of a patient; and _____
e. procedures placing the patient at risk or causing unusual pain. _____

12.2.9 The patient record shall contain documentation of patient and/or family consent for admission, treatment evaluation, aftercare, or research, as necessary. _____

12.2.10 The patient record shall contain both physical and emotional diagnoses, made with a recognized diagnostic system. _____

12.2.11 The patient record shall contain reports of laboratory, roentgenographic, or other diagnostic procedures. _____

12.2.12 The patient record shall contain reports of consultation. _____

12.2.13 The patient record shall contain reports of surgery performed. _____

12.2.14 The patient record shall contain reports of any patient-oriented multidisciplinary case conferences or consultations, which shall include the identity of attendees as well as recommendations made or actions taken. _____

12.2.15 The patient record shall contain correspondence related to the patient, and signed and dated notations of relevant telephone calls regarding the patient's treatment. _____

12.2.16 The patient record shall contain a discharge summary. _____

12.2.17 The patient record shall contain a plan for aftercare. _____

12.2.18 All entries in the patient record shall be signed and dated. _____

12.2.18.1 Symbols and abbreviations shall be used only if they have been approved by the clinical staff, and when there is an explanatory legend. _____

12.2.18.2 Symbols or abbreviations shall not be used when recording diagnoses. _____

12.3 The patient record shall contain special documentation of all procedures that place the patient at risk or in unusual pain including, but not limited to, the following:

a. restraint; _____

b. seclusion; and/or _____

c. behavior modification using painful stimuli. _____

12.3.1 Such records shall document the rationale or justification for the use of the procedure, the specific procedures employed, the required authorization, and the procedures employed to protect the patient's safety and rights. _____

12.4 Within 15 days after discharge, a discharge summary shall be entered in the patient's record. _____

12.4.1 The discharge summary shall include the initial formulation and diagnosis. _____

12.4.2 The discharge summary shall include the clinical resume, which shall summarize the following items:

a. the significant findings; _____

b. the course and progress of the patient with regard to each fundamental problem; _____

c. the clinical course of the patient's treatment and recommendations and arrangements for further treatment including prescribed medications and aftercare; and _____

d. the final formulation reflecting the general observations and understanding of the patient's condition initially, during treatment, and at discharge. _____

12.4.3 The discharge summary shall include the final primary and secondary diagnoses. _____

12.5 In the event of a patient's death, a summation statement shall be added to the record in the form of a discharge summary. The statement shall include the circumstances leading to death and shall be signed by a physician.

12.5.1 An autopsy shall be performed whenever possible, and, when performed, a provisional anatomic diagnosis shall be recorded in the patient record within 72 hours; the complete protocol shall be made a part of the record within three months.

12.6 The patient records department shall maintain, control, and supervise the patient records and maintain their quality.

12.6.1 The patient records department shall be the responsibility of an individual who has demonstrated competence and experience or training in patient records administration.

12.6.2 Appropriate patient records shall be kept on the unit where the patient is being treated and shall be directly accessible to the clinical staff caring for the patient.

12.6.3 There shall be written policies and procedures governing the compilation, storage, and dissemination of, as well as access to, patient records.

12.6.3.1 The policies and procedures shall be designed to ensure that the program fulfills its responsibility to safeguard and protect the patient record against loss, or unauthorized alteration or disclosure of information.

12.6.3.2 The policies and procedures shall be designed to ensure that the content and format of patient records are uniform.

12.6.3.3 The policies and procedures shall be designed to ensure that entries in the patient record are dated and signed.

12.6.4 The program shall provide adequate physical facilities for the storage, processing, and handling of patient records. The facilities shall include suitably locked and secured rooms and files.

12.6.5 When a program stores patient data on magnetic tape, computer files, or other types of automated information systems, adequate security measures shall prevent inadvertent or unauthorized access to such data.

12.6.6 The program shall maintain an indexing or referencing system that permits the location of a patient record that has been removed from the central file area.

12.7 There shall be a written policy governing the disposal of patient records.

12.7.1 Patient records shall be maintained for not less than five years from the date they are officially closed, or longer if legally required.

12.7.2 Methods of disposal shall be designed to assure the confidentiality of the information in the records.

12.8 There shall be written policies protecting the confidentiality of patient records and governing the disclosure of information from the records.

12.8.1 Such policies shall specify the conditions under which information on applicants or patients may be disclosed and the procedures for releasing such information.

12.8.2 A patient or authorized guardian may consent to a release of information provided that written consent is given on a form containing the following items:

a. the name of the person, agency, or organization to which the information is to be disclosed;

b. the specific information to be disclosed;

c. the purpose for the disclosure;

d. the date the consent was signed and the signature of the individual witnessing the consent; and

e. a notice that the consent is valid only for a specified period of time.

12.8.3 A patient's written consent for the disclosure of information shall be considered valid only if the following conditions have been met.

12.8.3.1 The patient shall be informed, in a manner that strives to assure his or her understanding, of the specific type of information that has been requested, as well as the benefits and disadvantages of releasing the information, if known.

12.8.3.2 The patient shall give consent freely and voluntarily.

12.8.3.3 The patient shall be informed that treatment services are not contingent upon the patient's decision concerning the release of information.

12.8.3.4 The consent shall be in accordance with the standards contained herein and any applicable federal, state, or local laws, rules, or regulations.

12.8.4 Every authorization for the release of information, the actual date the release was made, and the signature of the staff member releasing the information shall be made a part of the patient record.

12.8.5 Staff members or persons having access to patients' records shall be required to abide by the written program policies regarding the confidentiality of patient records and regarding the disclosure of information from the records, as well as any applicable federal, state, or local laws, rules, or regulations.

12.8.6 In a life-threatening situation or when an individual's condition or situation precludes the possibility of obtaining written consent, the program may release pertinent medical information to the medical personnel responsible for the individual's care without the individual's authorization, and without the authorization of the chief executive officer or a designee, if obtaining such authorization would cause an excessive delay in delivering treatment to the individual. When information has been released under such conditions, the staff member responsible for the release of information shall enter into the individual's record all details pertinent to the transaction, which shall include at least the following items:

a. the date the information was released;

b. the person to whom the information was released; _____

c. the reason the information was released; _____

d. the reason written consent could not be obtained; and _____

e. the nature and details of the information given. _____

12.8.6.1 As soon as possible after the release of information, the patient or applicant shall be informed that such information was released. _____

12.9 Patient records shall comply with all standards stated herein, and all applicable federal, state, and local laws and regulations. _____

Overall compliance: patient records _____

Comments and recommendations

Provide specific documentation for each 2 or 3 rating.

Patient management

13. Intake

13.1 The acceptance of a patient for treatment shall be based on an intake procedure and assessment of the patient. _____

13.1.1 Acceptance of a patient for treatment shall be based on an intake procedure that determines the following:

a. a patient requires treatment which is appropriate to the intensity and restrictions of care provided by the program or program component; and/or _____

b. the treatment required can be appropriately provided by the program or program component; and _____

c. alternatives for less intensive and restrictive treatment are not available. _____

13.1.2 Criteria for determining the eligibility of individuals for admission shall be clearly stated in writing. _____

13.1.3 Assessment shall be done by members of the clinical staff and be clearly explained to the patient. _____

13.1.3.1 The assessment shall be explained to the patient's family, when appropriate. _____

13.2 When a patient is found to be ineligible for admission, the reason shall be recorded in the patient intake record, and a referral to an appropriate agency or organization should be attempted. _____

13.2.1 The results of that referral attempt shall be documented. _____

13.3 A written confidential log shall be maintained and shall indicate the nature and disposition of all referrals received by the program. _____

13.4 Methods of intake shall be determined by the nature of the program and the needs of the patients it is designed to serve. _____

13.4.1 The program shall have written policies and procedures governing the intake process, including the following:

a. the types of information to be obtained on all applicants prior to admission; _____

b. the procedures to be followed when accepting referrals from outside agencies or organizations; _____

c. the types of records to be kept on all applicants; _____

d. statistical data to be kept regarding the intake process; and _____

e. the procedures to be followed, including those for referrals, when an applicant is found ineligible for admission. _____

13.4.2 During the intake process, every effort shall be made to assure that applicants understand the following:

a. the general nature and goals of the program; _____

b. the rules governing patient conduct and the types of infractions that can result in disciplinary action or discharge from the program; _____

c. the hours during which services are available in a nonresidential program; _____

d. the treatment costs to be borne by the patient, if any; and _____

e. the patients' rights. _____

13.4.3 When a patient is admitted on court order, the rights and responsibilities of the patient and family shall be explained. _____

13.4.3.1 This explanation shall be fully documented in the patient's record. _____

13.4.4 Sufficient information shall be collected during the intake process so that a tentative treatment plan can be developed. _____

13.5 The following information shall be recorded on standardized forms and shall become a part of the accepted patient's record:

a. name; _____

b. home address; _____

c. home telephone number; _____

d. date of birth; _____

e. sex; _____

f. race or ethnic origin; _____

g. next of kin; _____

h. education (current school and grade if applicable); _____

i. marital status; _____

j. type and place of employment; _____

k. date of initial contact or admission to the program; _____

l. legal status, when appropriate, including relevant legal documents; _____

m. other identifying data as indicated; _____

n. date the information was gathered; and _____

o. signature of the staff member gathering the information. _____

13.6 All programs which house patients overnight shall document the following items for each patient:

a. responsibility for financial support; _____

b. responsibility for medical and dental care, including consents for medical or surgical care and treatment; _____

c. arrangements for appropriate family participation in the treatment program; _____

d. arrangements for appropriate phone calls and visits when indicated; _____

e. arrangements for clothing, allowances, and gifts; and _____

f. arrangements regarding the patient's departure from the program with or without clinical consent. _____

13.7 Staff members who will be working with the patient, but who did not participate in the initial assessment, shall be informed about the patient prior to meeting him or her. _____

Overall compliance: intake _____

Comments and recommendations
Provide specific documentation for each 2 or 3 rating.

14. Assessment

14.1 The program shall be responsible for a complete patient assessment that includes clinical consideration of each of the fundamental needs. _____

14.1.1 This shall include, but is not limited to, an assessment of the physical, psychological, chronological age, developmental, family educational, social cultural, environmental, recreational, and vocational needs of the patient. _____

14.1.2 Clinical consideration of each area of the fundamental needs of the patient shall include the determination of the type and extent of special clinical examinations, tests, and evaluations necessary for a complete assessment. _____

14.2 The assessment of the patient's physical health shall be the responsibility of a qualified physician. _____

14.2.1 The physical health assessment shall include a complete medical and drug history. _____

14.2.2 In inpatient programs, the physical health assessment shall include a complete physical examination and, when indicated, a neurological assessment. _____

14.2.2.1 A complete physical examination must be completed within 24 hours after admission to any adult psychiatric or child/adolescent inpatient program. _____

14.2.2.2 In inpatient alcoholism and drug abuse programs, a physical examination must be completed before commencing detoxification or before administering prescription drugs. _____

14.2.3 In residential and outpatient programs, documentation shall verify that a determination of the necessity of a physical examination was made prior to the development and implementation of the patient's treatment plan. _____

14.2.3.1 There shall be a written procedure for determining the necessity of a physical examination. _____

14.2.3.1.1 Documentation shall verify that this procedure was developed in consultation with a physician. _____

14.2.3.2 The steps employed in determining the need for a physical examination shall include, but are not limited to, the following:

a. routine inquiry of every patient of when last treated by a physician and when last complete physical examination was done; _____

b. awareness of the presence of any medical problem; and _____

c. what, if any, medication is being taken.

14.2.3.3 If a physical examination is determined to be necessary, the process and results of this examination shall be documented in the patient's record.

14.2.3.4 Documentation shall verify that the physical examination is obtained during the patient's present course of treatment.

14.2.4 Residential and/or outpatient programs shall have a written plan for the provision of physical examinations, if such services are not directly provided by the program.

14.2.5 The physical health assessment shall include an appropriate laboratory workup.

14.2.6 If, just prior to admission to the program, a complete physical history has been recorded and a complete physical examination has been performed by the patient's physician, the signed report of this examination and history may be made part of the patient's record.

14.2.7 In addition to the requirements outlined in Sections 14.2 through 14.2.6, the physical health assessments in child and adolescent programs shall include evaluations of the following:

a. motor development and functioning;

b. sensorimotor functionings;

c. speech, hearing, and language functioning;

d. visual functioning; and

e. immunization status.

14.2.7.1 If a patient's immunization is not complete according to the USPHS Advisory Committee on Control of Infectious Diseases of the American Academy of Pediatrics, then the program shall complete it.

14.2.7.2 Child and adolescent programs shall have available all necessary diagnostic tools for physical health assessments, including EEG equipment, a qualified technician trained in dealing with children and adolescents, and a properly qualified physician to interpret the electroencephalographic tracing of children and adolescents.

14.2.7.2.1 Programs without EEG equipment and such staff must have written arrangements with another facility to provide such services.

14.3 There shall be an assessment procedure for the early detection of mental health problems that are life threatening or indicative of severe personality disorganization or deterioration, or that may seriously affect the treatment or rehabilitation process.

14.3.1 For each patient, a psychological assessment shall be completed and entered in the patient's record. The psychological assessment shall include, but is not limited to, the following items:

a. history of psychological problem areas;

b. family history;

c. previous psychiatric treatment; _____
d. direct psychological observation and behavioral appraisal; _____
e. a psychodynamic appraisal; _____
f. when indicated, intellectual, projective, and personality testing; and _____
g. when indicated, evaluations of language, cognition, self-help, and social-affective and visual-motor functioning. _____

14.3.2 In child and adolescent programs, the psychological assessment shall also include an assessment of the developmental/chronological age of the patient, including, but not necessarily limited to, the following items:

a. a developmental history from the prenatal period to the present; _____
b. the rate of progress; _____
c. developmental milestones; _____
d. developmental problems; _____
e. an evaluation of the patient's strengths as well as problems; and _____
f. an assessment of the patient's current age-appropriate developmental needs, which shall include a detailed appraisal of peer and group relationships and activities. _____

14.4 For each patient, a social assessment shall be undertaken and shall include information relating to the following areas:

a. environment and home; _____
b. religion; _____
c. childhood history; _____
d. military service history; _____
e. financial status; _____
f. drug and alcohol usage among other members of the family or household; _____
g. evaluation of the characteristics of the social, peer-group, and environmental settings from which the patient comes; _____
h. evaluation of the patient's family circumstances, including the constellation of the family group, the current living situation, and all social, religious, ethnic, cultural, financial, emotional, and health factors; and _____
i. evaluation of the expectations of the family regarding the patient's treatment, the degree to which they expect to be involved, and their expectations regarding the length of time and type of treatment required. _____

14.5 For each patient, a vocational status assessment shall be undertaken which shall include the following areas:

a. vocational history; _____
b. educational history, including academic and vocational training; and _____
c. a preliminary discussion between the individual and the staff member doing the assessment concerning the individual's past experiences with and attitudes toward work, present motivations or areas of interest, and possibilities for future education, training, and/or employment. _____

14.6 A nutritional assessment shall be included in the patient's record for those patients who, for medical reasons, require a special diet regimen. _____

14.7 For each patient, an activities assessment shall be undertaken which shall include information relating to the individual's current skills, talents, aptitudes, and interests, and include assessments of the following:

a. physical abilities and limitations; _____

b. ability to financially afford various forms of activities; _____

c. amount of leisure time available; and _____

d. motivations for engaging in various activities. _____

14.8 In drug abuse programs, a legal assessment of each patient shall be undertaken which shall include the following areas as a minimum:

a. legal history; and _____

b. a preliminary discussion to determine the extent to which the individual's legal situation will influence progress in treatment and the urgency of the legal situation. _____

14.8.1 No part of these standards dealing with legal assistance is intended to contravene any established laws or rules of court or any principle of ethics related to the practice of law. Where a conflict exists between these standards and the laws or rules of court or ethical principles, said laws, rules, or principles shall prevail. _____

Overall compliance: assessment _____

Comments and recommendations

Provide specific documentation for each 2 or 3 rating.

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15. Treatment plans

15.1 Each patient shall have an individualized written treatment plan which is based upon the assessments of that patient's fundamental needs. _____

15.1.1 The treatment plan shall be developed as soon after the patient's admission as possible. _____

15.1.2 Appropriate therapeutic efforts may begin before finalization of the treatment plan. _____

15.1.3 The treatment plan shall be a reflection of the program's philosophy of treatment and shall reflect appropriate multidisciplinary input by the staff. _____

15.1.4 The overall responsibility of the treatment plan shall be assigned to a member of the clinical staff. _____

15.1.5 The plan shall specify services required for meeting the patient's needs. _____

15.1.6 The plan shall include referral for needed services not provided directly by the program. _____

15.1.7 Speech, language, academic education, and hearing services shall be available when appropriate either within the program or by written arrangement with a qualified clinician or facility in order to meet the patient's needs. _____

15.1.8 The treatment plan shall include clinical consideration of the patient's fundamental needs. _____

15.1.9 Goals necessary for the patient to achieve, maintain, and/or re-establish emotional and/or physical health and maximum growth and adaptive capabilities shall be included in the treatment plan. _____

15.1.9.1 These goals shall be determined on the basis of the assessment of the patient and/or the patient's family. _____

15.1.9.2 Specific goals with both long-term and short-term objectives and the anticipated time expected to meet these goals shall be established. _____

15.1.9.3 Treatment plan goals shall be written in terms of measurable criteria. _____

15.1.10 The patient shall participate in the development of the treatment plan, and such participation shall be documented. _____

15.1.11 The treatment plan shall describe services, activities, programs, and anticipated patient actions and responses, as well as specify the staff assigned to work with the patient.

15.1.12 The treatment plan shall delineate the locations and frequency of treatment procedures.

15.1.13 The treatment plan shall designate the means for measuring the progress and/or outcome of treatment efforts.

15.1.14 The treatment plan shall delineate the specific criteria to be met for termination of treatment and aftercare services. Such criteria shall be a part of the initial treatment plan.

15.1.15 A specific plan for the involvement of the family or significant others shall be included in the treatment plan, when indicated.

15.2 Treatment procedures which place the patient at physical risk or in pain shall require special justification.

15.2.1 The rationale for the use of such procedures shall be clearly stated in the treatment plan.

15.2.2 Evidence in the treatment plan shall verify that such treatment procedures have been specifically reviewed by the head of the clinical staff before implementation.

15.2.3 The plan for such treatment procedures shall be consistent with the patient's rights and with the program's policies governing the procedures' use.

15.2.4 The clinical indications for the use of such procedures shall be documented in the patient's record.

15.2.5 The clinical indications shall outweigh the known contraindications for the individual patient.

15.3 The use of physical restraint or seclusion shall require clinical justification and shall be employed only to protect a patient from self-injury or from injuring others, and shall not be employed as punishment, as a convenience for staff, or as a mechanism to produce regression.

15.3.1 There shall be observation and examination of the patient prior to the writing of the order for the use of physical restraint or seclusion.

15.3.2 The rationale and authorization for the use of restraint or seclusion shall be clearly set forth in the patient's record by the clinical staff member responsible for the patient.

15.3.3 The written order shall specify the length of time restraint or seclusion is to be used.

15.3.3.1 The written order of a physician, renewable every 24 hours, shall be required for the use of restraint or seclusion for a period longer than one hour.

15.3.4 The staff implementing the written order shall have documented training in the proper application of restraints and the use of seclusion.

15.3.5 All use of physical restraints or seclusion shall be reported to the head of the clinical staff daily.

15.3.6 The written approval of the head of the clinical staff shall be required when physical restraint or seclusion is utilized for the continuing treatment of a patient for longer than a 24-hour period.

15.3.7 The head of the clinical staff shall review the program's use of physical restraint and seclusion daily and investigate unusual or unwarranted patterns of utilization.

15.3.8 Physical restraint or seclusion shall be used in such a manner as not to cause any undue physical discomfort, harm, or pain.

15.3.9 Every 15 minutes, appropriate attention shall be paid to a patient in physical restraint or seclusion, especially with regard to regular meals, bathing, and use of the toilet.

15.3.10 Physical restraint or seclusion may be employed in the event of an emergency without a written order under the following conditions.

15.3.10.1 When restraint or seclusion is employed in an emergency situation, a written order for physical restraint or seclusion shall be given by a member of the clinical staff who is qualified by experience and training in the use and application of physical restraint and seclusion.

15.3.10.2 When restraint or seclusion is employed in an emergency situation, the written order of the psychiatrist or other clinical staff member responsible for the patient's individual treatment plan shall be obtained in less than four hours.

15.4 The program shall have specific written policies and procedures governing the use of electroconvulsive therapy and other forms of convulsive therapy.

15.4.1 Written informed consent of the patient shall be obtained and made a part of the patient's record. The patient may withdraw consent at any time.

15.4.2 In child and adolescent programs, electroconvulsive therapy or other forms of convulsive therapy shall not be administered unless, prior to the initiation of treatment, two qualified psychiatrists with training or experience in the treatment of children and adolescents, who are not affiliated with the treating program, have examined the patient, have consulted with the responsible psychiatrist, and have written and signed reports in the patient's record which show concurrence with the decision to administer such treatment.

15.4.2.1 For patients under the age of 13, documentation that such reviews are carried out only by qualified child psychiatrists shall be included in the patient's record.

15.4.3 In circumstances when the family and/or legal guardian are required to give written informed consent, such person(s) may withdraw consent at any time.

15.5 There shall be written policies and procedures for the initiation of lobotomies or other surgical procedures for the intervention in or alteration of a mental, emotional, or behavioral disorder to be performed on adult patients.

15.5.1 Lobotomies shall not be performed on any adult patient unless, prior to the initiation of such treatment, one qualified psychiatrist who is not affiliated with the treating program has examined the patient, consulted with the responsible psychiatrist, and written and signed a report which shows concurrence with the decision to administer such treatment. _____

15.5.1.1 Documentation of such consultation shall be in the patient's record. _____

15.5.2 Policies shall prohibit lobotomies or other surgical procedures for the intervention in or alteration of a mental, emotional, or behavioral disorder in children or adolescents. _____

15.6 Documentation shall verify that an evaluation of the fundamental needs of the patient has been completed prior to discharge. _____

15.6.1 Documentation shall confirm that this evaluation is initiated by appropriate clinical staff as early as the clinical condition permits. _____

15.6.2 Documentation shall confirm that this evaluation is used as the basis for the patient's long-term treatment plan. _____

15.6.3 Documentation shall confirm that this evaluation is available to other components of the program. _____

15.6.4 Documentation shall confirm that this evaluation is available to other community service agencies that will provide continuous care following discharge. This information shall be made available only with the written consent of the patient, consistent with the program's patients' rights policies governing the release of confidential information. _____

15.7 Progress shall be reviewed regularly at multidisciplinary case conferences that are oriented toward evaluation of the individual patient's treatment plan as well as evaluation of the patient's progress in meeting the stated treatment goals. _____

15.7.1 Results of these reviews shall be entered in the patient's record. _____

15.8 Progress notes shall be entered in the patient's record and include the following items:

a. chronological documentation of the patient's clinical course; _____
b. documentation of all treatment rendered to the patient; _____
c. documentation of the implementation of the treatment plan; _____
d. descriptions of each change in each of the patient's conditions; _____
e. descriptions of responses to and outcomes of treatment; and _____
f. descriptions of the responses of the patient, patient's family, and/or significant others to significant intercurrent events. _____

15.8.1 Progress notes shall be dated and signed by the individual making the entry. _____

15.8.2 All entries that involve subjective interpretation of the patient's progress should be supplemented with a description of the actual behavior observed. _____

15.8.3 Efforts should be made to secure written reports of progress and other patient records for patients receiving services from an outside resource.

15.8.4 When available, outside resource patient records shall be included in the patient's record.

15.9 Reviews of and changes in the treatment plan shall be recorded in the patient's record.

15.9.1 Progress and current status in meeting goals outlined in the treatment plan shall be recorded regularly in the patient's record.

15.9.2 Efforts by staff members to help the patient achieve stated goals shall be recorded regularly.

15.10 The treatment plan shall be reviewed and updated regularly.

15.10.1 Programs with an anticipated length of stay of under three months shall review treatment plans no less frequently than within the first 72 hours, after one week, and every two weeks thereafter for the duration of active treatment.

15.10.2 Programs with an anticipated length of stay of three to twelve months shall review treatment plans no less frequently than required by the schedule outlined in Section 15.10.1 for the first three months and every three months thereafter for the duration of active treatment.

15.10.3 Programs with an anticipated length of stay of longer than twelve months shall review treatment plans according to the schedules outlined in Sections 15.10.1 and 15.10.2 and every six months thereafter for the duration of active treatment.

15.10.4 In an outpatient situation, treatment plans shall be reviewed no later than after the sixth outpatient session of assessment and treatment and once a month for the first three months thereafter. Subsequent treatment plan reviews shall be held at least once every three months for the first twelve months of treatment and no less frequently than every six months following the first twelve months of treatment.

15.11 A discharge note shall be completed within 15 days after discharge and shall be in accordance with the "Patient records" section of these *Standards*.

15.12 There shall be a written aftercare plan developed, with the participation of the patient, prior to the completion of treatment.

15.12.1 The individual aftercare plan shall be designed to establish continued contact for the support of the patient.

15.12.2 The aftercare plan shall include, but not be limited to, the methods and procedures whereby the needs of the individual are met by the aftercare personnel through direct contact and/or assistance from other community human service resources.

15.12.3 Documentation shall verify that the aftercare plan is jointly formulated by prior treatment providers, aftercare personnel, the patient, and the patient's family.

15.12.4 Documentation shall verify that the patient has a specific point of contact to facilitate obtaining needed services.

15.12.5 A periodic review and updating of the aftercare plan shall be carried out. _____

15.12.5.1 The frequency of review and update of the aftercare plan shall be determined jointly by the treatment providers and the patient. _____

15.12.6 The aftercare plan shall include criteria for reentry into primary treatment and for termination of aftercare services. _____

15.12.7 As a means for ensuring contact if the patient intends to relocate, the aftercare plan may include provisions for referral to another aftercare agency. _____

Overall compliance: treatment plans _____

Comments and recommendations
Provide specific documentation for each 2 or 3 rating.

Patient services

16. Activity services

16.1 The program shall provide activity services to meet the physical, social, cultural, recreational, health maintenance, and rehabilitation needs of patients. These services shall be included in the therapeutic treatment program of each patient. Activity services involve the principles and practices of many disciplines which may include, but are not limited to, art, dance, movement, music, occupational therapy, and recreational therapy. _____

16.2 There shall be a written plan describing the organization of the activity service, or the arrangements for the provision of such services, to meet the needs of patients. _____

16.3 The activity service shall be supervised by a qualified individual assisted by staff sufficient in number and skills to meet the needs of the patients and to achieve program goals. _____

16.3.1 Activity service staff shall receive training and demonstrate competence in handling medical and psychiatric emergency situations. _____

16.3.2 Activity service staff shall participate in appropriate clinical and administrative committees and conferences. _____

16.3.3 The activity service shall maintain ongoing staff development programs, and shall encourage extramural studies of, evaluation of, and research on activity services. _____

16.4 The activity service shall have written policies and procedures that are consistent with those of the program and are reviewed and revised as necessary. _____

16.4.1 The objectives of the activity service shall be stated in writing. _____

16.4.2 The activity service shall have written procedures for ongoing review and revision of its goals, objectives, and role within the program. _____

16.4.3 The activity service shall maintain statistical and other records concerning the functioning and utilization of the service. _____

16.4.4 Activity service staff shall collaborate with other clinical staff members in the delineation of the patients' treatment, health maintenance, and vocational adjustment goals. _____

16.4.5 The written activity service policies and procedures shall be made known and made available to all activity service personnel, as well as to other appropriate personnel. _____

16.5 When activity services are indicated, they shall be incorporated in the patient's treatment plan. _____

16.5.1 The treatment plan shall be formulated after assessment of, and according to, the individual patient's needs, interests, life experiences, capacities, and deficiencies. _____

16.5.2 Progress notes in the patient record shall be used for documenting the responses to activity service treatment and other pertinent observations. _____

16.6 Appropriate activity services shall be provided for all patients for daytime, evenings, and weekends to meet their needs and the goals of the program, and shall be posted where patients and staff have access to them. _____

16.6.1 The daily program of activities shall be planned to provide a consistent, well-structured, yet flexible, framework for daily living, and shall be reviewed and revised according to the changing needs of patients. _____

16.6.2 Whenever possible, patients should participate in the planning of activity services. _____

16.7 Documentation shall verify that leisure time is provided for patients and that there is a mechanism by which they are encouraged to use the time in a way that fulfills their own cultural and recreational interests and feelings of human dignity. _____

16.8 Suitable and appropriate space, equipment, and facilities for activity services shall be provided to meet the needs of patients. _____

16.8.1 Suitable and appropriate space, equipment, and facilities shall be designated and constructed or modified to permit all activity services to be provided, to the fullest extent possible, in pleasant and functional surroundings, and to be accessible to all patients, regardless of their disabilities. _____

16.8.2 When indicated, equipment should be utilized that enables the service to be brought to the patient. _____

16.8.3 There shall be adequate and accessible space for offices, storage, and supplies, suitable to the age group the program serves. _____

16.8.4 Space, equipment, and facilities utilized both inside and outside the program shall meet federal, state, and local requirements for safety, fire prevention, health, and sanitation. _____

16.9 The activity service shall have a well-organized plan for the utilization of community resources. _____

16.10 All labeling of vehicles used for transportation of patients shall be such that it does not call unnecessary attention to the patients. _____

Overall compliance: activity services _____

Comments and recommendations

Provide specific documentation for each 2 or 3 rating.

17. Anesthesia services

17.1 Anesthesia care shall be available in programs that provide surgical or obstetrical services and/or utilize anesthetic agents in electroconvulsive therapy or other health care procedures.

17.2 Anesthesia services shall be directed by a physician member of the staff, who shall have overall administrative responsibility for the service. Whenever possible, the director of anesthesia services shall be a physician specialist in anesthesiology.

17.2.1 The director's responsibilities shall include, but are not limited to, the following:

a. selecting and assigning all individuals with primary responsibility for anesthesia;

b. monitoring the quality of anesthesia care rendered by anesthetists throughout the program;

c. making recommendations on the type and amount of equipment necessary for administering anesthesia and for related resuscitative efforts, ensuring through at least annual review that such equipment is available;

d. developing regulations concerning anesthetic safety;

e. ensuring that retrospective evaluation of the quality of anesthesia care is carried out through appropriate audit or clinical care evaluation studies;

f. establishing a program of continuing education for all anesthesia staff, which includes inservice training and is based in part on the results of the evaluation of anesthesia care; and

g. establishing and monitoring a system for the recording of all pertinent events taking place during the induction of, maintenance of, and emergence from anesthesia.

17.3 At all times, anesthesia care shall be provided by anesthesiologists, other qualified physician or dentist anesthetists, qualified nurse anesthetists, or supervised trainees in an approved education program.

17.3.1 Physician anesthetists shall perform the following services, as required:

a. using accepted anesthetic procedures, render patients insensible to pain during the performance of surgical, obstetrical, electroconvulsive, and other pain-producing clinical procedures;

b. support life functions during the period of anesthesia administration, including induction and intubation procedures;

c. provide appropriate preanesthesia and postanesthesia management of patients; and

d. provide consultation relating to respiratory therapy, emergency cardiopulmonary resuscitation, and special problems in pain relief.

17.3.2 Qualified nurse or dentist anesthetists shall have competence to perform the following services, as required:

a. induce anesthesia;

b. maintain anesthesia at the required levels;

c. support life functions during the period in which anesthesia is administered, including induction and intubation procedures;

d. recognize and take appropriate action (including requesting consultation when necessary) for abnormal patient responses to anesthesia, or to any adjunctive medication or other form of therapy; and

e. provide professional observation and resuscitative care (including requesting consultation when necessary) until the patient has regained control of his or her vital functions.

17.4 Controls shall be established to minimize electrical hazards in all anesthetizing areas, as well as hazards of fire and explosion in areas in which flammable anesthetic agents are used. Anesthesia safety regulations should be developed by, or be under the supervision of, the director of anesthesia services in conjunction with the program safety committee, be approved by appropriate representatives of the clinical staff and administration, and be reviewed annually. Such regulations shall include at least the following items.

17.4.1 Anesthetic apparatus shall be inspected and tested by the anesthetist before use. If a leak or any other defect is observed, the equipment shall not be used until repaired.

17.4.2 Only nonflammable agents shall be used for anesthesia, or for the preoperative preparation of the surgical field, when electrical equipment employing an open spark, such as cautery or coagulation equipment, is to be used during an operation.

17.4.3 Flammable anesthetic agents shall be employed only in areas in which a conductive pathway can be maintained between the patient and a conductive floor.

17.4.4 All personnel shall wear conductive footwear, where required, which should be tested for conductivity before entering the area.

17.4.5 All equipment in the surgical suite shall be fitted with grounding devices, where required, to maintain a constant conductive pathway to the floor.

17.4.6 The fabrics permissible for use in outer garments or blankets in anesthetizing areas shall be specified.

17.4.7 With the exceptions of certain radiological equipment and fixed lighting more than five feet above the floor, all electrical equipment in anesthetizing areas shall be on an audiovisual line isolation monitor. When this device indicates a hazard, the administration of flammable anesthetic agents should be discontinued as soon as possible; the use of any electrical gear should be avoided, particularly the last

electrical item put into use as well as any item not required for patient monitoring or support; and the program engineer or maintenance chief shall be notified immediately. Following completion of this procedure, the operating room from which the signal emanated should not be used until the defect is remedied.

17.4.7.1 All personnel who work in such areas shall be familiar with the procedures to be followed.

17.4.8 The operating room electrical equipment, such as cords, plugs, switches, and various electronic devices, shall be inspected regularly, and the conductivity of equipment should be tested by a qualified engineer.

17.4.8.1 A written record of the results of these inspections should be maintained.

17.5 Because individuals with varying backgrounds may administer anesthetic agents, the clinical staff must approve, enforce, and document the implementation of written policies on anesthesia procedures.

17.5.1 The policies shall include the delineation of preanesthesia and postanesthesia responsibilities.

17.5.2 The policies shall delineate the qualifications of those authorized to administer anesthesia.

17.5.3 The policies shall provide for a preanesthesia evaluation of the patient by a physician who will provide appropriate documentation in the patient's record on choice of anesthesia and procedure anticipated. This evaluation should include the patient's previous drug history, other anesthetic experiences, and descriptions of any potential anesthetic problems.

17.5.4 The policies shall provide for an appraisal of the patient's condition immediately prior to induction of anesthesia and should include a review of the completeness of the patient's record, pertinent laboratory data, and the dosage and time of administration of preanesthesia medications. Any change in the patient's condition compared to the patient's condition on previous visits should be noted in the patient's record.

17.5.5 The policies shall provide for the safety of the patient during the anesthetic period.

17.5.6 The policies shall provide that the readiness, availability, cleanliness, and working condition of all equipment used in administration of anesthetic agents be checked by the anesthetist prior to the administration of anesthesia.

17.5.7 The policies shall provide that each anesthetic gas machine have a pin-index safety system.

17.5.8 The policies shall provide that the anesthetist or a designee remain with the patient as long as necessary following the procedure for which anesthesia was administered.

17.5.9 The policies shall provide that the personnel responsible for postanesthesia care should be advised of specific problems presented by the patient's condition.

17.5.10 The policies shall provide that decisions regarding the discharge of patients from any postanesthesia care unit should be made by a physician. _____

17.5.11 The policies shall provide for the recording of physiological events taking place during the induction of, maintenance of, and emergence from anesthesia, including the dosage and duration of all anesthetic agents, other drugs, intravenous fluids, and blood or blood fractions. _____

17.5.12 The policies shall provide for the recording of psychiatric events taking place during the induction of, maintenance of, and emergence from anesthesia, including observations of the patient's emotional and mental condition and behavior. _____

17.5.13 The policies shall provide for the recording of postanesthesia visits which include at least one note describing the presence or absence of anesthesia-related complications, and observations of the patient's emotional and mental condition and behavior. _____

Overall compliance: anesthesia services _____

Comments and recommendations
Provide specific documentation for each 2 or 3 rating.

18. Community education services (optional)

18.1 When a program has an organized community education service, it shall be designed to increase community understanding of the nature of the specific program, the treatment and prevention of the disability, and the human and legal rights of the population at risk, as well as to inform the public of existing service resources and gain public support for the development of additional resources. _____

18.1.1 The community education service shall have a written plan describing its philosophy and goals, the services available, and the means by which the community's awareness and acceptance of the disability is increased. _____

18.1.1.1 The written plan shall provide documentation which describes the participation in the community education service of relevant organizations, individuals, and agencies on a regular and planned basis throughout each year. _____

18.1.1.2 The written plan shall document procedures by which attention is focused on understanding the general and specific needs, with regard to the disability, of persons and their families and their right to participate in the mainstream of community life. _____

18.1.1.2.1 Such procedures may include, but are not limited to, the following devices:

a. brochures or fact sheets on services currently provided; _____

b. newsletters; _____

c. audiovisual materials; _____

d. a speaker's bureau; _____

e. meeting and seminar presentations; _____

f. school presentations; _____

g. a total media publicity program, including press releases and interviews of staff and patients; and _____

h. a library and/or bibliography of books and publications for use by staff, patients, and members of the general public. _____

18.1.1.3 The written plan shall designate places and/or persons responsible for the collection and dissemination of information about the disability. _____

18.1.1.3.1 Efforts to inform the community of the availability of those persons and/or places from which information about the disability can be obtained shall be documented. _____

18.1.1.3.2 The educational effort may be coordinated and/or integrated with the educational efforts of other human services both inside and outside the program. _____

18.1.1.4 The written plan shall provide for documentation of measures implemented to educate the general public concerning the needs of the population at risk that remain unmet and of measures implemented to stimulate social action. _____

18.1.1.4.1 The means of stimulating social action may include, but are not limited to, the following techniques:

a. using volunteers in the community education service; _____

b. involving citizens in writing and otherwise contacting their legislators in support of needed legislation; _____

c. sponsoring special events in support of program needs that appeal to broad community interests; _____

d. conducting activities that express and recognize citizen support of program needs; _____

e. recognizing community leaders for their participation in and support of new program developments; _____

f. encouraging fraternal, civic, and social organizations to support programs and the families of patients in programs; and _____

g. identifying special audiences, such as public officials, and conducting special information sessions. _____

18.1.1.5 The written plan shall describe the lines of authority among, and utilization of, personnel with appropriate skills for providing community education services. _____

18.1.1.5.1 A person shall be specifically designated to hold the responsibility for the functioning of the community education service. _____

18.1.1.6 The written plan shall delineate the interrelationship between the community education service staff and the staff of all other services. _____

18.1.1.7 Documentation shall verify that the written plan is distributed to and reviewed by all staff members at least annually. _____

18.1.2 There shall be a written plan for the training of all personnel in the community education service. _____

18.1.2.1 The written plan shall designate an individual in charge of training who will assume responsibility for the content of both the plan and the training program. _____

18.1.2.2 Documentation shall verify that the training plan has been implemented. _____

18.1.2.3 Documentation shall verify that the training plan is updated annually to adjust to changing needs. _____

Overall compliance: community education services _____

Comments and recommendations

Provide specific documentation for each 2 or 3 rating.

19. Consultation services (optional)

19.1 When a program has a consultation service, the service shall be designed to provide to the individual or group seeking aid the requisite skills for coping more adequately with issues involving care and/or program administration. _____

19.2 The consultation service shall have a written plan. _____

19.2.1 The plan shall describe the procedures by which the consultation needs of community groups and/or agencies are assessed. _____

19.2.1.1 Documentation shall verify the participation of relevant community groups and/or agencies in the needs assessment. _____

19.2.1.2 The goals and objectives of the consultation service shall be derived from the assessment of the consultation needs. _____

19.2.2 The plan shall describe the procedures for implementing these goals and objectives. _____

19.2.2.1 Documentation shall verify the participation of relevant community groups and/or agencies in the formulation of procedures for implementing the goals and objectives. _____

19.2.3 The plan shall describe the lines of authority among and the utilization of personnel with appropriate skills for the consultation effort. _____

19.2.3.1 A person shall be specifically designated to hold the responsibility for the functioning of the consultation service. _____

19.2.4 The plan shall delineate the interrelationship between consultation service staff and the staff of all other services. _____

19.2.5 Documentation shall verify that the plan is distributed to and reviewed at least annually by consultation service staff members and the participating community groups and/or agencies. _____

19.3 The agreements between the consultation service and participating community groups and/or agencies should be documented. _____

19.3.1 The agreements shall delineate the general and specific responsibilities of the service and of the community groups and/or agencies. _____

19.4 There shall be a written plan for the training of all personnel in the consultation service. _____

19.4.1 The written plan shall designate an individual in charge of training who will assume responsibility for the content of both the plan and the training program. _____

19.4.2 Documentation shall verify that the training plan has been implemented. _____

19.4.3 Documentation shall verify that the training plan is updated annually to adjust to changing needs. _____

Overall compliance: consultation services _____

Comments and recommendations
Provide specific documentation for each 2 or 3 rating.

20. Dental services

20.1 The program shall have a written plan outlining the procedures whereby the dental health care needs of patients are assessed and treatment provided. _____

20.1.1 The written dental health plan shall delineate the following:

a. mechanisms for evaluating the need for dental treatment; _____

b. provisions for emergency dental services; _____

c. policies on oral hygiene and preventive dentistry; _____

d. provisions for coordinating dental services with other services provided by the program; and _____

e. a mechanism for the referral of patients for services not provided. _____

20.2 When a program provides dental services, a written policy shall delineate the functions of the service and the specific services provided. _____

20.2.1 The dental service shall be directed by a fully licensed dentist member of the clinical staff who is qualified to assume organizational and administrative responsibility for the dental service. _____

20.2.2 The dental service shall have a sufficient number of adequately trained personnel to meet the needs of patients. _____

20.2.3 The dental service shall have adequate space, equipment, instruments, and supplies to meet the needs of patients. _____

20.3 Reports of all dental services provided shall be made a part of the patient's record. _____

Overall compliance: dental services _____

Comments and recommendations

Provide specific documentation for each 2 or 3 rating.

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21. Dietetic services

21.1 Programs providing 24-hour care, having therapeutic goals relative to the nutritional needs of patients, or having patients requiring dietetic services shall have a written plan describing the organization and delivery of dietetic services, or the arrangements for the provision of such services, to meet the needs of patients. _____

21.1.1 If such services are provided by an outside company, the contractual agreement between the program and the company shall require the company to comply with the service's written plan and the standards of this section. _____

21.1.2 The plan shall require that the dietetic service be directed by an individual who by training and/or experience is knowledgeable in food service management. _____

21.1.3 The plan shall require the utilization on a full-time, part-time, or consultation basis of at least one qualified dietitian who has the following qualifications:

a. is registered or eligible for registration by the Commission on Dietetic Registration; or _____

b. has the documented equivalent in education, training, and experience, with evidence of relevant continuing education. _____

21.1.4 The plan shall describe the utilization of the qualified dietitian. _____

21.1.4.1 The nutritional aspects of patient care shall be under the direction of the qualified or registered dietitian or other appropriate persons under the supervision of the dietitian. _____

21.1.4.2 When a part-time or consultant dietitian is utilized, the hours of the dietitian shall be such as to perform the following tasks:

a. ensure continuity of service; _____

b. direct the nutritional aspects of patient care; _____

c. ensure that dietetic instructions are carried out; _____

d. on occasion, supervise the serving of meals; and _____

e. assist in the evaluation of the service. _____

21.1.4.3 When a qualified or registered dietitian serves in a consultant status, regular written reports should be submitted to the chief executive officer concerning the extent of services provided by the dietitian. _____

21.1.5 The written plan shall provide for meeting the nutritional needs of patients, especially those with special dietary needs, e.g., those with food allergies or those, such as children and adolescents and the elderly, unable to accept a regular diet. _____

21.2 The service shall have an adequate number of appropriately qualified individuals to meet its responsibilities. _____

21.3 There shall be written policies and procedures governing all aspects of dietetic services. _____

21.3.1 The policies and procedures shall delineate the responsibilities and authority assigned to staff. _____

21.3.2 The policies and procedures shall include provisions for dietetic counseling. _____

21.3.3 The policies and procedures shall provide that special dietetic orders should be recorded in the patient's record. _____

21.3.4 The policies and procedures shall include provisions designed to ensure that all observations and information pertinent to dietetic treatment are recorded in the patient's record. _____

21.3.5 The policies and procedures shall specify that standards for nutritional care should be used to aid in evaluating the nutritional adequacy of the patient's diet and in ordering diet supplements. The current *Recommended Dietary Allowances* of the Food and Nutrition Board of the National Research Council of the National Academy of Sciences is suggested as a guide in developing these standards. _____

21.3.6 The policies and procedures shall provide that when patients are assigned to the dietetic service for therapeutic or vocational purposes, the method of their assignment shall be in accordance with the policies and procedures of the program. _____

21.3.7 The policies and procedures shall describe the methods for ensuring that each patient receives the prescribed diet regimen when special diets are ordered. _____

21.3.8 The policies and procedures shall include mechanisms for altering diets or diet schedules as well as discontinuing diets. _____

21.3.9 The policies and procedures shall be designed to ensure that, when medically indicated, diet information will be forwarded upon the patient's discharge to another institution or facility. _____

21.3.10 The policies and procedures shall include requirements for the ancillary dietetic services, including food storage and preparation in kitchens or patients' units, formula supply, vending operations, and ice-making. _____

21.3.11 The policies and procedures shall require that the dietetic service be maintained in a safe and sanitary manner, particularly in the preparation and handling of food, the care and cleaning of equipment and work areas, and the washing of dishes. _____

21.3.12 The policies and procedures shall include requirements for food purchasing, storage, preparation, and service. _____

21.3.13 The policies and procedures shall include requirements regarding the health and hygiene of personnel. _____

21.3.13.1 Dietetic service employees shall be free of infectious and open skin lesions. _____

21.3.13.2 Health policies for dietetic service employees shall be in compliance with federal, state, and local laws and regulations. _____

21.3.13.3 The health policies for patients assigned to the dietetic service for therapeutic or vocational purposes shall be the same as for dietetic service employees. _____

21.3.14 The policies and procedures shall include provisions for the discarding of plastic ware, china, glassware, or similar items that have lost their glaze or are chipped or cracked. _____

21.3.15 The policies and procedures shall include requirements for the control of lighting, ventilation, and humidity to prevent condensation of moisture and growth of molds. _____

21.3.16 The policies and procedures shall provide that dish and utensil washing equipment and techniques will be used which will result in sanitized serviceware and prevent contamination. _____

21.3.17 The policies and procedures shall provide that contamination in the making, storing, and dispensing of ice be avoided and that ice stored for dispensing be dispensed by a scoop and not have food items stored directly on it. _____

21.3.18 The policies and procedures shall provide that disposable containers and utensils be discarded after one use. _____

21.3.19 The policies and procedures shall provide that unauthorized personnel be restricted from the food service area. _____

21.4 All menus shall be approved by a qualified dietitian. _____

21.4.1 An up-to-date diet manual shall be used that is approved by a dietitian and the program's physicians. The manual shall be reviewed annually and revised as necessary by a qualified dietitian and dated to identify the time of the review. Any revisions made shall be approved by the program's physicians. _____

21.4.2 The ordering of diets should be standardized through the use of this diet manual. _____

21.4.3 The nutritional deficiencies of any diet in the manual shall be indicated. _____

21.5 Dietetic service personnel shall conduct periodic food acceptance studies among the patients and should encourage them to participate in menu planning. _____

21.5.1 The results of the food acceptance studies should be incorporated into revised menus. _____

21.6 Food shall be served in an appetizing and attractive manner, at realistically planned mealtimes, and in a congenial and relaxed atmosphere. Dining areas should be attractive and be maintained at appropriate temperatures. _____

21.6.1 The dietetic service shall be patient-oriented and should take into account the wide variations of eating habits, including cultural, religious, and ethnic needs of the individual patient. _____

21.6.2 Snacks shall be available as appropriate to the nutritional needs of the patient and the needs of the program. _____

21.6.3 The dietetic service shall be prepared to supply extra food for individual children, and to provide the extra amounts of food needed by children and adolescents. At the same time, appropriate foods should be available for children and adolescents with special or limited dietary needs. _____

21.7 Dietetic service personnel shall be trained regarding the behavior and the therapeutic needs of the patients. _____

21.7.1 Dietetic service personnel shall assist patients, when necessary, in making appropriate food choices from the daily planned menu. _____

21.7.2 Dietetic service personnel shall be aware that emotional factors may cause changes in the food habits of the patients and shall communicate any changes to the clinical staff. _____

21.8 Adequate space, equipment, and supplies, as well as any necessary written procedures and precautions, shall be provided to ensure the safe and sanitary operation of the dietetic service and the safe and sanitary handling and distribution of food. _____

21.8.1 The dietitian's office should be easily accessible to all who require consultation service. _____

21.8.2 The food service area should be appropriately located. _____

21.8.3 Sufficient space shall be provided for supportive personnel to perform their duties. _____

21.8.4 The layout of the department, in combination with the type, size, and placement of equipment, shall make the efficient preparation and distribution of food possible. _____

21.9 The dietetic service shall be in compliance with all applicable federal, state, and local sanitation and safety laws and regulations. _____

21.10 The dietetic service shall have policies governing the handling and preparation of foods. _____

21.10.1 All refrigerators and freezers on the premises shall be capable of being opened from the inside regardless of whether or not they are being used. _____

21.10.2 Hot and cold water pipes, water heaters, refrigerators, compressors, condensing units, and uncontrolled heat-producing equipment shall be insulated. _____

21.10.3 Supplies shall be clearly labeled. _____

21.10.4 All nonfood supplies shall be stored in an area separate from that in which food supplies are stored. _____

21.10.5 Food shall be procured from sources that provide assurance that the food is processed under regulated quality and sanitation controls. _____

21.10.6 Food shall be protected from contamination and spoilage. _____

21.10.7 Perishable foods shall be stored at proper temperatures, using an appropriate thermometer and maintaining temperature records. _____

21.10.8 Adequate hand-washing and hand-drying facilities shall be located in convenient places throughout the food service area. _____

21.10.9 Thorough cleansing and sanitizing of all working surfaces, utensils, and equipment shall occur after each period of use. _____

21.10.10 The holding, transferring, and disposing of garbage shall be done so as not to create a nuisance, a breeding place for insects and rodents, or a medium for transmission of disease. _____

21.10.11 Garbage containers shall be leakproof and nonabsorbent and have close-fitting covers. _____

21.10.12 All garbage containers should have impervious plastic liners. _____

21.11 The role of the dietetic service in the program's internal and external disaster plan shall be clearly defined. The service shall be able to meet the nutritional needs of patients and staff during a disaster, consistent with the capabilities of the program and community served. _____

Overall compliance: dietetic services _____

Comments and recommendations

Provide specific documentation for each 2 or 3 rating.

22. Educational services

22.1 Inpatient and residential programs shall provide or arrange for educational services to meet the needs of all patients. _____

22.1.1 The services shall include the provision of special education experiences for those whose emotional disturbances make it difficult for them to learn. _____

22.1.2 The services shall include the maintenance and progression of education and intellectual development for all patients during their period of disability. _____

22.1.3 The services shall include the opportunity to remedy deficits in education for those who have fallen behind because of their disorder. _____

22.2 When a program operates its own education service, it shall have adequate staff and space to meet the needs of patients. _____

22.2.1 An education director and staff who meet state and/or local certification requirements for education and/or special education shall be provided. _____

22.2.2 An appropriate ratio of teachers to students shall be provided so teachers can give special attention, as needed, to individual students and groups of students who are at different stages of treatment and education. _____

22.2.3 The service shall have adequate classroom and other space, and a sufficient quantity of educational materials, appropriate to its scope. _____

22.3 When clinically indicated, patients shall participate in education programs in the community. Teachers in the community shall be given such information as needed to work most effectively with the patient. _____

22.4 Patients who are able to do so shall be encouraged to take part in extracurricular school activities. _____

22.5 There shall be documentation in each patient's record of periodic reevaluations of educational achievement in relation to that patient's developmental level, chronological age, sex, special handicaps, medication, and psychotherapeutic needs. _____

22.5.1 The clinical staff shall periodically have conferences with teachers or principals regarding individual patients, their progress, and any special problems that arise. _____

Overall compliance: educational services _____

Comments and recommendations
Provide specific documentation for each 2 or 3 rating.

23. Outreach services (optional)

23.1 The outreach service shall be designed to facilitate identification (within a target population) of persons who have problems related to mental health, alcoholism, or drug abuse; to facilitate procurement of health services for those persons and their families; to alert all public and private human service agencies that serve the same target population to the importance of early problem identification; and to provide easy access to the service delivery system. It is essential that the outreach process involve as many organizations, agencies, and individuals as may be in contact with a part of the target population. _____

23.2 The outreach service shall have a written plan which includes the following items:

a. a description of its service philosophy, objectives, and organization; _____

b. a justification of the primary outreach procedures that are utilized; _____

c. a description of the indicators used to measure progress toward attainment of objectives; _____

d. a description of the role of the individual in charge of the service; _____

e. specifications of the lines of authority within the service; _____

f. descriptions of the roles and responsibilities of outreach personnel; _____

g. descriptions of the methods of personnel utilization; and _____

h. a delineation of the interrelationship of the service and its personnel with other service providers, both inside and outside the program. _____

23.2.1 The annual review, updating, and approval of the organization plan, service philosophy, and objectives by representatives of the administrative and service staffs shall be documented. _____

23.3 Outreach services shall include, but are not limited to, the following activities:

a. identifying persons in need of services, locating services to meet their needs, assisting them in entering the service delivery system, and ensuring contact at the point of entry; _____

b. alerting relevant agencies and individuals to the importance of early problem detection and to their role as case finders (alerting those who serve high-risk populations is especially important); and _____

c. maintaining liaison and interaction with all relevant community organizations and agencies. _____

23.3.1 The implementation of these outreach service activities shall be documented. _____

23.4 The outreach service shall maintain documentation verifying that outreach personnel report the activities of, and recommendations regarding, patients to any individual, agency, and/or organization that has assisted in the identification of patients. _____

23.5 A plan shall be written for the training of all outreach personnel. _____

23.5.1 The written plan shall designate an individual in charge of training who will assume responsibility for the content of both the plan and the training program. _____

23.5.2 Documentation shall verify that the training plan has been implemented. _____

23.5.3 Documentation shall verify that the training plan is updated annually to adjust to changing needs. _____

Overall compliance: outreach services _____

Comments and recommendations

Provide specific documentation for each 2 or 3 rating.

24. Pathology services

24.1 Pathology and laboratory services shall be provided according to the needs of the patients, the size of the program, the services that the program offers, and the resources available to the community.

24.1.1 The services shall be provided by one of the following methods:

a. the program shall provide the services; or

b. the services shall be provided through a contractual agreement with an outside facility that is in a hospital accredited by JCAH, is an independent laboratory approved by the Commission on Inspection and Accreditation of the College of American Pathologists, or is a laboratory that meets equivalent standards.

24.1.2 The pathology and laboratory services to be provided shall include examinations in the field of hematology, chemistry, microbiology, clinical microscopy, and seroimmunology in sufficient depth to meet the usual needs of the clinical staff in caring for the patients.

24.1.3 A written plan shall clearly identify the means of providing pathology services and the position of those services in the overall organization of the program.

24.2 When pathology and laboratory services are provided by the program, there shall be written policies and procedures governing the operation of the service.

24.2.1 The pathology and laboratory service shall be directed by a physician member of the active clinical staff who is qualified through education and/or experience to assume this responsibility. When such direction is provided by other than a pathologist, a pathologist shall provide overall supervision on a consulting basis.

24.2.2 The number of laboratory technologists/technicians shall be sufficient to promptly and proficiently perform the tests required of the laboratory.

24.2.3 Work areas in the laboratory should be arranged so as to minimize problems in transportation and communication and should be adequately lighted so as to facilitate accuracy and precision. Bench space should be adequate and conveniently located for the efficient handling of specimens and for the housing of equipment and reagents.

24.2.4 Pathology service equipment and instruments should be appropriate to the services rendered. Electrical outlets with adequately stabilized voltage should be sufficient in number and properly grounded. Special precautions should be taken to avoid unnecessary physical, chemical, and biological hazards.

24.2.5 The pathology service shall subscribe to an acceptable method of quality control. _____

24.2.6 Orders or requisitions for services shall clearly identify the patient and responsible physician and shall indicate the tests requested, the date and time the request reached the laboratory, and any special handling required. Requests for examinations of surgical specimens should contain a concise statement of the reason for the examination. _____

24.2.7 Written procedures should be developed that are designed to assure that satisfactory specimens are collected for the tests to be performed. _____

24.2.8 A record should be maintained of the daily collection of specimens, each of which should be numbered or otherwise appropriately identified. This record should contain at least the following information:

a. laboratory procedure number or other identification; _____
b. identification of the patient; _____
c. name of the requesting staff member; _____
d. date and time the specimen was collected; _____
e. date, time, and by whom the specimen was examined; _____
f. condition of any unsatisfactory specimen; _____
g. type of test or procedure performed; and _____
h. result and date result was reported. _____

24.2.9 Space and equipment in the necropsy area shall be adequate to accommodate the usual work load. Lighting should be sufficient to facilitate the identification of inconspicuous lesions. Ventilation should minimize discomfort for personnel working in the area, as well as for patients and other personnel in the program. _____

24.2.9.1 Each necropsy shall be performed by a pathologist or a physician who is sufficiently qualified in anatomic pathology to give reasonable assurance that significant lesions are recognized. _____

24.2.9.2 Each necropsy procedure, and the record thereof, shall be thorough and detailed. Provisional anatomic diagnoses should be recorded in the patient's record within 72 hours, when feasible; the complete protocol should be made part of the patient's record within three months. _____

Overall compliance: pathology services _____

Comments and recommendations
Provide specific documentation for each 2 or 3 rating.

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25. Pharmacy services

25.1 The program shall provide or make arrangements for pharmaceutical services, where indicated, to meet the needs of patients. These services may be provided by agreement with another facility, through a community pharmacy, or through an organized pharmaceutical service within the program. _____

25.1.1 When the program has an organized pharmacy service, the director shall be a graduate of a recognized college of pharmacy, or a person of equivalent education and/or experience. _____

25.1.1.1 The director shall be oriented to the specialized functions of the program. _____

25.1.1.2 The director may be employed on either a part-time or full-time basis, as the scope of the service requires. _____

25.1.1.3 The director shall be assisted by additional qualified pharmacists and ancillary personnel, as needed. _____

25.2 Whatever the arrangement, a pharmacist shall be responsible for written policies and procedures that govern the safe storage, preparation, distribution, and administration of drugs in accordance with applicable federal, state, and local laws and regulations and shall perform the following activities. _____

25.2.1 A pharmacist shall be responsible for the following:

a. the admixture of parenteral products; _____

b. compounding pharmaceuticals; _____

c. establishing specifications for the procurement of all drugs, chemicals, and biologicals; _____

d. participating in the development of a program formulary, the existence of which does not preclude the use of unlisted drugs, and a formulary system to be approved by the appropriate program staff; _____

e. dispensing drugs and chemicals, including provisions for emergency service; _____

f. filling and labeling all drug containers that are issued to departments, services, or units from which medications are to be administered; _____

g. implementing the decisions concerning drug usage of relevant program committees; and _____

h. maintaining and keeping available the approved stock of antidotes and other emergency drugs, both in the pharmacy and in patient care areas. _____

25.2.2 A pharmacist should assist in the preparation of drug treatment plans by providing the following information for inclusion in the patient's record and for use by the staff:

a. instructions regarding the drug product, dosage form, route of administration, and time of administration with respect to meals, other drugs, and activities;

b. a schedule of laboratory tests necessary to detect adverse reactions or to monitor drug therapy; and

c. a description of potential adverse reactions.

25.2.3 Unless otherwise provided by law, the pharmacist should regularly review the medication records of patients.

25.2.4 To ensure continuity of care when the patient is to be transferred, the pharmacist should provide the receiving program with information on the patient's drug regimen. This information should also be provided, with the patient's approval, to the patient's community pharmacist and private physician.

25.2.5 Pharmacy assistants shall work under the supervision of a pharmacist and shall not be assigned duties that are required to be performed only by registered pharmacists.

25.2.6 The pharmacist should participate in staff development programs for clinical staff members.

25.2.7 The pharmacist should participate in drug abuse education programs.

25.2.8 A pharmacist should participate in public education and informational programs relative to the services of the program.

25.2.9 Under the supervision of the pharmacist, an appropriately trained or experienced individual shall make at least monthly inspections of all drug storage units, including emergency boxes and emergency carts.

25.2.9.1 A record of these inspections shall be maintained to verify that the following conditions are maintained.

25.2.9.1.1 Disinfectants and drugs for external use shall be stored separately from internal and injectable drugs.

25.2.9.1.2 Drugs requiring special conditions for storage to ensure stability shall be properly stored in a separate compartment within a refrigerator that is capable of maintaining the necessary temperature.

25.2.9.1.3 Outdated drugs shall not be stocked.

25.2.9.1.4 Distribution and administration of controlled drugs shall be adequately documented.

25.2.9.1.5 Emergency drugs shall be kept in adequate and proper supply.

25.2.9.1.6 An emergency kit shall be maintained that meets the following requirements:

a. made up in consultation with a physician;

b. readily available to staff, yet not accessible to patients; _____

c. constituted to be appropriate to the needs of the patients; and _____

d. inspected after use and at least monthly to remove deteriorated and outdated drugs and ensure completeness of content. _____

25.2.9.1.7 The physician responsible for the emergency kit shall provide a list of its contents and appropriate instructions for use, authenticating this list with his or her signature. _____

25.3 Adequate precautions shall be taken regarding storage of medications under proper sanitation, temperature, light, moisture, ventilation, segregation, and security conditions. _____

25.3.1 All drugs shall be kept in locked storage. _____

25.3.2 Security conditions shall be maintained in accordance with local and state laws. _____

25.3.3 Poisons, external drugs, and internal drugs shall be stored on separate shelves or in separate containers. _____

25.4 All medication orders shall meet the following conditions. _____

25.4.1 Medication orders shall be written only by authorized prescribers. _____

25.4.1.1 An updated list of authorized medication prescribers shall be available in all areas where medication is dispensed. _____

25.4.1.2 Telephone orders shall be accepted only from those whose names appear on the authorized list. _____

25.4.1.3 Telephone orders shall be accepted and written in the patient's record only by the staff authorized to dispense medication. _____

25.4.1.4 Telephone orders shall be limited to emergency situations which are written and defined by the program. _____

25.4.1.4.1 Situations which constitute an emergency shall be defined in the program's policies and procedures manual. _____

25.4.1.5 Telephone orders shall be signed by a responsible physician on the next regular working day (not to exceed 72 hours). _____

25.4.1.6 A written order signed by the authorized prescriber shall be included in the patient's record. _____

25.4.2 Orders involving abbreviations and chemical symbols shall be carried out only if the abbreviations and symbols appear on a standard list approved by the physician members of the clinical staff. _____

25.4.3 There shall be automatic stop orders on specified medications, and all medication orders shall be reviewed monthly by the responsible physician or dentist. _____

25.4.4 In programs that provide pharmaceutical services through a community pharmacy, medications shall be obtained by a written prescription of a physician or dentist member of the clinical staff. _____

25.4.5 The prescribing and dispensing of drugs that have abuse potential shall be undertaken only when the following criteria are met:

a. a staff physician has reviewed the patient's record and has entered into the record the reasons for prescribing the given drug(s);

b. the drug to be prescribed appears in the program's formulary; and

c. prior to the initiation of such therapy, the patient and where required by law, parent or guardian are informed, both orally and in writing, and, if possible, in the patient's native language of the benefits and hazards of the drug to be prescribed.

25.5 Medications shall be administered in accordance with the following conditions.

25.5.1 If in accordance with the approval of the physician members of the staff and federal, state, and local laws and regulations, clinical staff members other than physicians, registered nurses, or licensed practical nurses shall administer medications under the supervision of a physician, registered nurse, or licensed practical nurse.

25.5.1.1 A medication administration training program for clinical staff members, approved by a physician, shall be provided.

25.5.1.2 The content of the training programs shall be in writing, available for review, and include at least the following:

a. appropriate information about the nature of the drug(s) to be administered;

b. supervised training in the administration of medications; and

c. familiarization with the expected actions and side effects of the drug(s) to be administered.

25.5.2 A list of clinical staff members authorized by the program and by law to administer medications shall be maintained and regularly updated.

25.5.3 Self-administration of medication shall be permitted only when specifically ordered by the responsible physician, in nonmedical components only when the patient has a prescription from a physician, and shall be supervised in all cases by a member of the clinical staff.

25.5.3.1 If patients bring their own drugs into the program, these drugs shall not be administered unless they can be absolutely identified, and written orders to administer these specific drugs are given by the responsible physician.

25.5.3.2 If the drugs that the patient brings to the program are not to be used, they shall be packaged, sealed, and stored and returned to the patient, family, or significant others at the time of discharge, if such action is approved by the responsible physician.

25.5.4 The patient, and where appropriate, the family shall be instructed in which medications are being administered by the clinical staff and which, if any, are to be administered at home.

25.5.5 Documentation of medications administered, medication errors, and adverse drug reactions shall be entered in the patient's record.

25.5.6 Adverse drug reactions and medication errors shall be reported to the physician responsible for the patient, and shall be documented in the patient's record. _____

25.5.6.1 Programs should implement a reporting system under which the reporting program of the Federal Food and Drug Administration and the drug manufacturer are advised of unexpected adverse drug reactions. _____

25.5.7 There shall be methods of detecting drug side effects or toxic reactions. _____

25.5.8 Investigational drugs shall be used only under the direct supervision of the principal investigator with the approval of the physician members of the staff or appropriate committee of the staff, and the research review committee. _____

25.5.8.1 A central unit shall be established where essential information on investigational drugs is maintained, including drug dosage form, dosage range, storage requirements, adverse reactions, usage, and contraindication. _____

25.5.8.2 Investigational drugs shall be properly labeled. _____

25.5.8.3 Nurses may administer investigational drugs only after receiving basic pharmacologic information about the drugs. _____

25.6 The program shall have specific methods for controlling and accounting for drug products. _____

25.6.1 The pharmacy service shall maintain records of its transactions as required by law and as necessary to maintain adequate control of and accountability for all drugs. This shall include a system of supplies to units, departments, or services of the program, as well as records of all prescription drugs dispensed. _____

25.6.2 Records and inventories of the drugs listed in the current Comprehensive Drug Abuse Prevention and Control Act shall be maintained as required by the act and regulations. _____

25.7 Drug preparation and storage areas shall be well-lighted and located so that personnel will not be interrupted when handling drugs. _____

25.7.1 Antidote charts and the telephone number of the regional poison control center shall be kept in all drug storage and preparation areas. _____

25.7.2 Metric apothecaries weight and measure conversion charts shall be posted in each drug preparation area and wherever else needed. _____

25.7.3 Up-to-date pharmaceutical reference material shall be provided so that program staff will have adequate information concerning drugs. _____

25.7.4 Current editions of text and reference books shall be provided covering theoretical and practical pharmacy; general, organic, pharmaceutical, and biological chemistry; toxicology; pharmacology; bacteriology; sterilization and disinfection; and other subjects important to good patient care. _____

Overall compliance: pharmacy services _____

Comments and recommendations
Provide specific documentation for each 2 or 3 rating.

26. Radiology services

26.1 According to the needs of the patients, radiology services shall be conveniently available, as ordered by a clinical staff member with appropriate clinical privileges, through a radiology service within the program or through arrangements with an outside source approved by the clinical staff.

26.1.1 Any such arrangements shall be outlined in a written plan.

26.2 When radiology services are provided by the program, written policies and procedures shall govern the operation of the service.

26.2.1 The radiology service shall have a radiologist to direct the service and to give consultation. This individual shall, preferably, be certified by the American Board of Radiology or have equivalent education and experience. The director shall be available on a full-time or part-time basis, depending upon the size and complexity of the radiology service.

26.2.2 The radiology service shall provide appropriate facilities for radiographic and fluoroscopic diagnostic services. Each service area should be easily accessible to patients needing such services, regardless of their disabilities. The personnel, space, and equipment for the reception, examination, and treatment of patients and for related clerical work shall be adequate.

26.2.2.1 Radiological equipment shall be calibrated periodically. Calibration of equipment, and all safety measures followed, shall be in compliance with the applicable federal, state, and local laws and regulations.

26.2.2.1.1 A written calibration record should be kept.

26.2.2.2 So that personnel and patients are not endangered, proper safety precautions shall be maintained within the radiology service to guard against electrical, mechanical, and radiation hazards, as well as against fire and explosion. The latest recommendations of the National Council on Radiation Protection and Measurements should be followed. Radiation monitoring of personnel and areas should be carried out through the use of appropriate measuring devices.

26.2.3 A radiologist shall provide an authenticated report for each examination to ensure consistency in interpretations and reports of radiological findings.

26.2.4 At least one qualified radiological technologist shall be on duty or available at all times.

26.2.5 Instructions in safety precautions and in dealing with emergency radiation hazards shall be provided to all personnel. _____

26.2.6 Written policies and procedures shall be developed by the program's clinical staff. These policies and procedures shall be reviewed regularly, revised as necessary, and dated to indicate the time of last review. _____

26.2.6.1 The policies shall specify that radiology services be performed only upon the written order of a clinical staff member with appropriate clinical privileges and shall contain a concise statement of the reason for the request. _____

26.2.6.2 The policies shall include the procedures involved in preparing patients for radiological services. _____

26.2.6.3 The policies shall include the procedures for radiological examinations in areas other than the radiology service. _____

26.2.6.4 The policies shall include the criteria governing the administration of diagnostic agents by nonmedical personnel. _____

26.2.6.5 The policies shall include procedures for the care of patients having special needs, including those requiring special management, those who are critically ill, and those requiring isolation precautions. _____

Overall compliance: radiology services _____

Comments and recommendations
Provide specific documentation for each 2 or 3 rating.

27. Speech and hearing services

27.1 The program shall have speech, language, and hearing services available, either within the program or by written arrangement with a qualified clinician or facility, to provide assessments of speech, language, and hearing, when indicated, and to provide counseling, treatment, and rehabilitation of patients when such services are needed. _____

27.2 When speech, language, and hearing services are provided by the program, written policies and procedures shall govern the operation of the service. _____

27.2.1 The speech, language, and hearing service shall provide the following:

a. audiometric screening of new patients who have not had previous examinations; _____

b. speech and language screening of patients as deemed necessary by members of the treatment team, the family, or significant others; _____

c. comprehensive audiological assessment of patients when indicated; _____

d. the procurement, maintenance, and replacement of hearing aids as specified by a qualified audiologist; _____

e. comprehensive speech and language evaluation of patients as indicated by screening results; and _____

f. where appropriate, rehabilitation programs designed to establish the speech skills necessary for comprehension and expression. _____

27.2.2 Assessment and treatment shall be reported accurately and systematically and in such language as to accomplish the following tasks:

a. define the problem; _____

b. provide a basis for formulating a plan for treatment objectives and procedures; _____

c. provide information to staff working with the patient; and _____

d. provide evaluative and summary reports for inclusion in the patient's record. _____

27.2.3 Administration and supervision of the speech, language, and hearing service shall be provided by qualified speech-language and hearing clinicians. _____

27.2.3.1 All staff with independent responsibilities shall hold a Certificate of Clinical Competence or a Statement of Equivalence in either speech pathology or audiology issued by the American Speech and Hearing Association, or have documented equivalent

training and experience and shall meet current legal requirements of licensure or registration. _____

27.2.4 Support personnel, such as speech pathology assistants and communication aides, shall be qualified by training and/or experience for the level of work performed and shall be appropriately supervised by a staff speech-language pathologist or audiologist. _____

27.2.5 Equipment shall meet the standards of the American Board of Examiners in Speech Pathology and Audiology of the American Speech and Hearing Association and shall be located, calibrated, and maintained according to those standards. _____

Overall compliance: speech and hearing services _____

Comments and recommendations
Provide specific documentation for each 2 or 3 rating.

28. Vocational rehabilitation services

28.1 Patients shall receive counseling specifically oriented to their vocational needs, e.g., counseling in understanding their vocational strengths and weaknesses, the demands of their present and future jobs, the responsibilities of holding a job, and problems related to vocational training, placement, and employment. _____

28.2 A program may delegate vocational rehabilitation responsibilities to an outside vocational rehabilitation agency. However, the agency must assign a specific individual, with the approval of the program, to serve as the program's coordinator of vocational rehabilitation; and the agency must agree to follow the provisions of the standards presented herein. _____

28.3 If a program provides its own vocational rehabilitation service, written policies and procedures shall govern the operation of the service. _____

28.3.1 A sufficient number of appropriately qualified staff and support personnel shall be provided. _____

28.3.1.1 A person or team shall be designated to be responsible for the implementation of vocational rehabilitation services. _____

28.3.1.2 The program shall have at least one qualified vocational rehabilitation counselor available who is responsible for the professional standards, coordination, and delivery of vocational rehabilitation services. _____

28.3.1.3 All personnel providing vocational rehabilitation services shall have training, experience, and competence consistent with acceptable standards of their specialty field. _____

28.3.1.4 Sufficient numbers of qualified vocational rehabilitation counselors and support personnel shall be available to meet the needs of patients. _____

28.3.2 The vocational rehabilitation service shall assess the patient's vocational needs with regard to the following areas:

a. current work skills and potential for improving these skills or developing new ones; _____
b. educational background; _____
c. amenability to vocational counseling; _____
d. aptitudes, interests, and motivations for getting involved in various job-related activities; _____
e. physical abilities; _____
f. skills and experiences in seeking jobs; _____

g. work habits as related to tardiness, absenteeism, dependability, honesty, and relations with co-workers and supervisors; _____

h. personal grooming and appearance; and _____

i. expectations regarding the personal financial and social benefits to be derived from working. _____

28.3.3 Vocational services shall be provided according to an individualized treatment plan. _____

28.3.3.1 The criteria for determining a patient's job-readiness shall be stated in the patient's treatment plan. _____

28.3.4 A record shall be kept of vocational rehabilitation activities; it shall include the date, as well as a description, of the activity, participants, and results. _____

28.3.5 All work programs must conform to federal, state, and local rules and regulations. _____

Overall compliance: vocational rehabilitation services _____

Comments and recommendations

Provide specific documentation for each 2 or 3 rating.

Facility management

29. Building and grounds

29.1 The facility in which the program is housed shall be designed, constructed, and equipped in a manner that ensures the physical safety of patients, staff, and visitors against the hazards of fire, explosion, and panic.

29.1.1 The facility in which the program is housed shall comply with the 1973 edition of the NFPA *Life Safety Code*. (When a condition exists which is allowed by the 1967 edition of the NFPA *Life Safety Code* but not by the 1973 edition of the code, the facility shall be permitted to show that no additional risk is being incurred in the existing situation.)

29.1.2 Each facility in which a program is housed shall be responsible for determining, in cooperation with the authority having jurisdiction or other person having equivalent qualifications (i.e., a registered professional engineer, a registered architect, a member of the Society of Fire Protection Engineers, a qualified employee of a fire insurance rating organization, or a similarly qualified person), the section of the NFPA *Life Safety Code* under which each separate building falls.

29.1.2.1 For facilities designated as institutional occupancies, the provisions for hazardous areas in Section 10-137 of the 1973 edition of the NFPA *Life Safety Code* shall apply to both new and existing construction.

29.1.2.2 For facilities designated as residential occupancies, the provisions for hazardous areas in Section 11-235 of the 1973 edition of the NFPA *Life Safety Code* shall apply to both new and existing construction.

29.1.3 The facility in which the program is housed shall comply with all applicable local, state, and federal codes.

29.1.3.1 Where there is a conflict in the applicable standards or codes, the more restrictive provisions shall prevail.

29.1.4 The facility in which the program is housed shall maintain written evidence of a valid report of inspections by the authority having jurisdiction, or other person having equivalent qualifications for approving the facility.

29.1.4.1 The report shall show the extent of current compliance with the 1973 edition of the NFPA *Life Safety Code.*

29.1.5 In addition to the on-site survey, the structural safety shall be judged by documentary evidence in the form of a comprehensive Statement of Construction and Fire Protection to be furnished to JCAH by the program prior to the survey.

29.1.5.1 The program must submit to JCAH a plan of correction, with anticipated time of completion, for all physical plant deficiencies identified by authorized inspecting agencies or identified as a result of a JCAH survey.

29.1.5.2 In instances when the applications of these standards would be clearly impractical or an unnecessary hardship, the facility in which the program is housed shall provide documentation that the authority having jurisdiction has allowed alternative arrangements or granted exceptions which shall provide as nearly equivalent safety to life from fire as is practical.

29.1.5.3 Alternative arrangements or exceptions shall not be less restrictive or afford less safety to life than compliance with these standards.

29.1.5.4 In buildings constructed prior to 1973, documented alternative arrangements or exceptions granted by the authority having jurisdiction should include documented sustained extraordinary fire prevention measures in the form of effective housekeeping and maintenance practices; at least hourly fire watches of all patient-occupied areas by designated personnel; provision of adequate fire fighting equipment; adequate staffing to ensure the evaluation of all patients, staff, and visitors; fire drills on all work shifts in excess of the requirements of the 1973 edition of the NFPA *Life Safety Code;* and other measures required by the authority having jurisdiction.

29.1.6 In all new construction (a building for which the design was approved after 1973), provision shall be made for the safe and convenient use of the building in which the program is housed by handicapped individuals (patients, staff, and visitors).

29.1.6.1 Walkways and curbs shall be constructed to facilitate travel by individuals using wheelchairs or crutches.

29.1.6.2 Signals, such as elevator calls and fire alarms, shall be both audible and visible.

29.1.6.3 Elevator control buttons shall be accessible to wheelchair occupants.

29.1.6.4 An adequate number of conveniently located parking spaces shall be reserved for handicapped individuals.

29.1.6.5 Access to fountains, toilets, and handwashing facilities for all handicapped individuals shall be provided. _____

29.1.6.6 All facilities provided for individuals using wheelchairs shall be identified by the appropriate symbols (i.e., picture signs). _____

29.1.7 Protection shall be provided from sharp projections, "invisible" glass, moving parts, heated surfaces, or heavy objects which may fall. _____

29.1.8 Elevators in the facility in which the program is housed shall be adequately protected and supervised, and patients shall be protected from elevator-related hazards. _____

29.1.9 The facility in which the program is housed shall provide protection from unusual safety hazards, such as discarded refrigerators with doors, environmental hazards, sewer conduits, catch basins, and the like. _____

29.1.10 The facility in which the program is housed shall have specific plans and appropriate policies developed and followed pertaining to the usage, maintenance, and supervision of and safety precautions for any special activity areas or equipment, such as swimming pools, tennis courts, riding stables, or gymnasiums. _____

Overall compliance: building and grounds _____

Comments and recommendations

Provide specific documentation for each 2 or 3 rating.

30. Functional safety and sanitation

30.1 There shall be a program safety committee with representation from all major services. (This function may be performed by an already existing committee with related interests and responsibilities.)

30.1.1 The safety committee shall meet as required, but not less than monthly, and shall maintain written records of each meeting.

30.1.2 The responsibilities of the safety committee shall include the development of written policies and procedures designed to enhance, to the maximum degree possible, safety within the facility in which the program is housed and on its grounds.

30.1.2.1 The safety committee shall coordinate and cooperate in the development of safety rules and practices for the program.

30.1.2.2 The safety committee shall establish an incident reporting system that includes a mechanism for investigating and evaluating all incidents reported and for documenting the review of all such reports and the actions taken.

30.1.2.3 The safety committee shall act as a liaison with the infection control program, with which ideas shall be exchanged.

30.1.2.4 The safety committee shall provide safety-related information to be used in the orientation of all new employees and in the continuing education of all program employees.

30.1.2.5 The safety committee shall establish methods of measuring the results of the safety program and shall undertake a periodic analysis to determine the safety program's effectiveness, including a review of all pertinent records and reports.

References to and/or excerpts from the following standards are used with permission of the National Fire Protection Association (NFPA), Boston, Massachusetts: NFPA 3M, *Hospital Emergency Preparedness,* Copyright 1973; NFPA 10, *Installation, Maintenance, and Use of Portable Fire Extinguishers,* Copyright 1974; NFPA 13A, *Care & Maintenance of Sprinkler Systems,* Copyright 1971; NFPA 15, *Water Spray Fixed Systems,* Copyright 1973; NFPA 17, *Dry Chemical Extinguishing Systems,* Copyright 1973; NFPA 56A, *Inhalation Anesthetics,* Copyright 1973; NFPA 56B, *Respiratory Therapy,* Copyright 1973; NFPA 56C, *Laboratories in Health-Related Institutions,* Copyright 1973; NFPA 72D, *Proprietary Protective Signaling Systems,* Copyright 1974; NFPA 76A, *Essential Electrical Systems for Health Care Facilities,* Copyright 1973; NFPA 82, *Incinerators, Rubbish,* Copyright 1972; NFPA 90A, *Air Conditioning and Ventilating Systems,* Copyright 1975; NFPA 101, *Life Safety Code,* Copyright 1973.

While referenced here as resources, NFPA standards are designed to be used fully as they apply to hospital safety. Copies of these documents are available from the National Fire Protection Association, 470 Atlantic Avenue, Boston, Massachusetts 02210.

30.1.2.6 The safety committee shall develop a reference library of documents and publications dealing with all facets of facility safety. It is strongly recommended that copies of all applicable building and safety codes and standards be included.

30.2 A qualified individual shall be designated as safety director or officer.

30.2.1 The safety director or officer shall be familiar with the applicable local, state, federal, NFPA, and JCAH safety standards.

Electrical safety

30.3 Policies and procedures shall be established for a systematic, periodic evaluation of the electrical power distribution systems.

30.3.1 Such systems shall be tested/inspected when newly installed, and at least annually thereafter.

30.3.2 Written records of all inspections performed, including any actions taken or recommended, shall be maintained.

30.4 For all electrical and electronic patient care equipment, policies and procedures shall be established for methods and frequency of testing, and for verification of performance and use specifications.

30.4.1 All new electrical and electronic equipment must be tested within the first six months of operation.

30.4.2 Written records of all inspections performed, including any actions taken or recommended, shall be maintained.

30.5 Inspection/testing of nonclinical equipment shall be performed at regular intervals to be determined by the chief of the engineering/maintenance department and the results recorded.

30.6 There shall be a written policy on the use and testing of personal electrical equipment used by patients and staff.

30.7 There shall be a written policy on the use of extension cords and adapters.

30.8 Operating information for each item of electrical equipment shall be readily available to those responsible for its operation, maintenance, and inspection. A label on the equipment indicating the location of the information is acceptable. However, where feasible, operators' instruction booklets should be kept with the individual pieces of equipment with a master-file copy available in a designated location at all times.

30.9 Conductivity testing shall be carried out in all areas with conductive flooring, and the results shall be recorded.

30.9.1 All furniture in areas with conductive flooring shall be included in the conductivity testing.

30.9.1.1 Where flammable agents are no longer permitted for anesthesia or skin preparation of the operative field, conductive flooring is not required. In such cases, the conductivity characteristics of the floor may be eliminated by a means approved by the authority having jurisdiction.

30.10 An isolated power system shall be provided in all anesthetizing locations.

30.10.1 Each isolated power system shall employ a continually operating line isolation monitor which shall have both audible and visible signals.

30.10.2 Line isolation monitors shall be tested on at least a weekly basis and only when the circuit is not otherwise in use. A permanent record of the tests shall be maintained.

30.11 The program shall develop and implement an effective system for determining electrical current leakage, for ensuring proper grounding and the meeting of other safety requirements for devices, and for providing appropriate corrective measures.

30.12 Qualified advice and service concerning electrical and electronic systems and equipment, at all technical levels, shall be available.

Fire warning and safety systems

30.13 Every building shall have an electrically supervised and manually operated fire alarm that automatically transmits an alarm by the most direct and reliable method approved by local regulation to the fire department that is legally committed to serve the area in which the building is located.

30.13.1 A presignal system shall not be used.

30.13.2 When the fire station is not continually staffed, e.g., a volunteer service, the program shall have a direct connection to the local police or sheriff's department or equally attended and reliable source for summoning the fire department.

30.14 Manual fire alarm boxes shall be distributed throughout the facility and located so that they are unobstructed, readily accessible, and in the path of normal exit travel.

30.15 The audible signal devices of an internal alarm system shall produce signals that are distinctive from all other signals used for any purpose in the same area.

30.15.1 The audible alarm shall exceed the level of operational noise in any area.

30.16 Automatic fire extinguishing systems shall be compatible with the area to be protected and shall not cause a situation that in itself would endanger the safety of patients, personnel, or visitors.

30.17 Automatic sprinkler systems shall include a water flow alarm connected to the fire alarm system.

30.17.1 Where water pressure is inadequate to effectively operate the highest hose stations or sprinklers, automatic booster pumps shall be on electric service having standby power.

30.18 Sprinkler system control valves shall be examined at least weekly, should be sealed in the open position, shall be electrically monitored, and shall be labeled to indicate the fire area(s) served.

30.19 All fire warning and safety systems shall be inspected at least quarterly.

30.19.1 Written, dated, and authenticated records of all inspections and maintenance performed shall be maintained.

30.20 Fire extinguishers shall be of the type required for the class of fire normally anticipated in the area and shall be kept in their designated places when not in use.

30.20.1 Travel distance to each extinguisher in the area it serves shall not exceed 75 feet.

30.20.2 Fire extinguishers shall be inspected at least monthly and maintained at least annually; this shall be documented.

30.21 Exhaust hoods, grease removal devices, and ducts for commercial cooking ranges and deep fryers shall be equipped with approved automatic extinguishing systems. The system shall also serve to protect the cooking surfaces.

30.21.1 Portable extinguishers of the same type should also be available.

30.22 All hose stations and standpipes must be of a type approved by the authority having jurisdiction.

Compressed gas cylinders

30.23 All cylinders used for compressed gases shall be capped when not connected and secured at all times to prevent falling.

30.24 Empty cylinders shall be identified and stored separately from full or partially full cylinders.

30.25 All cylinder storage areas, outdoors and indoors, shall be protected from extremes of heat and cold, as defined by NFPA 56A,* and from access by unauthorized individuals.

Handling and storage of nonflammable gases

30.26 Oxidizing agents shall be stored separately from flammable gases and liquids.

30.26.1 The storage location shall be free of combustible materials.

30.27 When the quantity of gas stored exceeds 2000 cubic feet, the storage area shall be outside the building, or in a room that is of at least one hour fireresistive construction (or equipped with an approved automatic fire extinguishing system) and is vented to the outside.

30.28 There shall be a written policy and procedure for the prevention of fire hazards in the presence of an oxygen-enriched atmosphere.

*NFPA 56A—1973, *Standard for the Use of Inhalation Anesthetics (Flammable and Nonflammable)*

Handling and storage of flammable gases and liquids

30.29 Flammable gas and flammable liquid storage rooms or enclosures inside the facility shall be constructed to have a fireresistance rating of at least one hour.

30.30 Combustible materials shall not be stored with flammable gases or liquids.

30.31 Enclosures in which flammable anesthetizing agents are stored shall be individually and continuously ventilated either by gravity or by a mechanical means at a rate of not less than eight air changes per hour.

30.31.1 The enclosures shall have a fresh air inlet near the ceiling and an exhaust-air outlet near the floor.

30.32 Conductive flooring is required in storage locations for flammable anesthetic agents when such locations are a part of the operative or obstetrical suite.

30.33 There shall be a written procedure for the safe disposition of the residual ether left in anesthesia machines or in opened containers.

30.34 A relative humidity of at least 50 percent shall be maintained in all areas where anesthetizing agents are used.

30.35 All electrical equipment intended for use in anesthetizing areas shall be labeled by the manufacturer to indicate whether it may be used in a flammable anesthetizing location.

30.36 Storage of flammable gases within the laboratory shall, to the maximum extent possible, meet the same standards for enclosure as described for flammable anesthetizing gases in Sections 30.31 and 30.31.1.

30.37 The supply of flammable gas stored in the laboratory shall not ordinarily exceed the amount needed for two working days .

30.38 Quantities of flammable liquids in excess of ten gallons kept in one laboratory unit (an area comprising a maximum of 500 square feet) shall be stored in a listed storage cabinet containing not more than 60 gallons.

30.39 When a storage room is provided in lieu of a listed storage cabinet, the room shall be of at least one hour fireresistive construction or be equipped with an approved automatic fire extinguishing system, and shall be vented to the outside.

30.40 Flammable liquids or gas cylinders shall not be positioned near flame or heat sources.

30.41 Tissue processors and similar automatic equipment employing flammable or combustible reagents shall be well-ventilated and operated at least five feet from any storage area for combustible materials.

30.42 All refrigerators shall be labeled externally to indicate whether or not they are safe for storage of flammable liquids.

30.43 Alcohol shall be withdrawn from large drums only when the drum is in an upright position and an approved hand pump is used.

30.44 At anesthetizing locations where flammable anesthetic agents are not allowed, permanent signs shall be posted indicating that the use of such flammable agents is prohibited.

Emergency power

30.45 The program shall have an autonomous emergency power source available on its premises which is installed in accordance with NFPA 76A.* _____

30.46 A written record shall be maintained of inspections, performance, exercising period, and repairs of the emergency power source which shall be exercised under actual load conditions for a 30-minute period at least monthly. _____

30.47 The following area(s) and function(s) shall be served by the standby emergency electrical power source within ten seconds of failure of the normal power source:

a. egress illumination; _____
b. exit signs and exit directional signs; _____
c. fire, smoke, sprinkler, and oxygen alarms; _____
d. special care units; _____
e. operating rooms; _____
f. delivery rooms; _____
g. postoperative recovery rooms; _____
h. emergency care areas; _____
i. newborn nurseries ; _____
j. medication preparation areas; _____
k. nursing stations; _____
l. treatment rooms; _____
m. clinical laboratory task areas; _____
n. isolation transformers; _____
o. blood storage units; _____
p. program communication system; and _____
q. central suction system. _____

30.48 The following areas shall be served by the emergency power source on either a delayed automatic or manual basis:

a. medical air compressors; _____
b. at least one elevator per bank of elevators in a multistory patient-occupied building; and _____
c. heating equipment. _____

Patient and personnel safety devices and measures

30.49 Side rails shall be available for both sides of beds, for use when warranted by a patient's condition. _____

30.50 Nonambulatory patients shall have access to grab bars, and similar safety devices shall be installed in each patient's bathing and toilet area. _____

30.50.1 Grab bars shall be nonremovable. _____

*NFPA 76A—1973, *Standard for Essential Electrical Systems for Health Care Facilities*

30.51 An external emergency release mechanism shall be provided for the opening of bathroom doors that can be locked from the inside. _____

30.52 To prevent personal injury, the temperature of the hot water supply shall be regulated and shall not be over 110°F. (43°C.) at the outlet. _____

30.52.1 Hot water temperature control devices shall be inaccessible to unauthorized staff members, patients, and the public. _____

30.53 The use of portable heating devices shall be prohibited. _____

30.54 Facilities for flushing eyes, body, and clothing with large quantities of water shall be provided in or near the areas in which caustic or toxic materials are used. _____

30.55 Bulk concentrated acid and caustic material storage areas shall be identified and located near or at floor level. _____

30.56 Rooms in which volatile and/or toxic chemicals are used shall be adequately ventilated and equipped with noncombustible fume hoods. _____

30.57 Refrigerators for the storage of flammable material shall be provided as needed. _____

30.58 Radiation decontamination facilities shall be provided wherever radioactive isotopes are used. _____

30.59 Biological safety cabinets shall be provided for the protection of laboratory personnel who handle specimens known or suspected to contain microorganisms of a high virulence. _____

30.60 There shall be a written plan of emergency action which personnel shall implement in the event of any serious accident in the laboratory. _____

30.60.1 The provisions of the plan shall periodically be made known to all laboratory personnel. _____

30.61 A fire blanket and a self-contained breathing apparatus may be provided in the laboratory. _____

30.62 Staff shall be familiar with the policies for supervision of patients using special areas such as swimming pools. _____

30.63 In child or adolescent inpatient and residential programs, electrical outlets, radiators, and steam and hot water pipes shall have protective coverings or insulation. _____

30.64 All potentially dangerous or toxic substances shall be stored in a locked cabinet or enclosure. _____

30.65 Special safety considerations shall be given to building features which may harm patients, e.g., "invisible" glass doors, sharp protrusions, and heavy objects which may fall. _____

Smoking

30.66 There shall be written regulations governing smoking. _____

30.66.1 The regulations shall be conspicuously posted and made known to all program personnel, patients, and the public. _____

30.66.2 Smoking shall be prohibited in any area of the program where flammable liquids or gases, or oxygen are in use or stored. _____

30.66.3 Ambulatory patients shall not be permitted to smoke in bed. _____

30.66.4 Patients who are confined to bed and who are mentally and physically responsible for their actions should be discouraged from smoking. _____

30.66.5 Unsupervised smoking by patients who are not mentally or physically responsible for their actions shall be prohibited. _____

30.66.6 Wastebaskets and ashtrays shall be made of noncombustible materials, and wastebaskets shall not be used as ashtrays. _____

30.66.7 Smoking shall be prohibited in areas where combustible supplies or materials are stored. _____

30.66.8 Smoking by personnel using the surgical and obstetrical suites shall be limited to the dressing rooms and lounges, and doors leading to the suites shall be kept closed. _____

Security

30.67 Measures shall be taken to provide security for patients, personnel, and the public, consistent with the conditions and risks inherent in the program's location. _____

External disaster plan

30.68 When a program has been designated by local authority (i.e., fire department or civil defense officials or others) as an external disaster emergency center, the program shall have written plans for the proper and timely care of casualties arising from such disasters. _____

30.68.1 To establish an effective chain of command and to make appropriate jurisdictional provisions, planning should include consultation with local civil authorities and with representatives of other medical agencies. _____

30.68.2 The external disaster plan shall be rehearsed at least twice each year. _____

30.68.3 The external disaster plan shall provide for the following:

a. an efficient system of notifying and assigning personnel; _____

b. a unified medical command; _____

c. availability of adequate basic utilities and supplies, as well as essential medical and supportive materials; _____

d. procedures for the prompt discharge or transfer of patients in the program who can be moved safely; _____

e. conversion of all usable space to provide triage, observation, and treatment areas; _____

f. the transfer of transportable casualties to a facility where definitive care can be rendered; _____

g. the use of a special disaster medical record to accompany the casualty; _____

h. establishment of a centralized public information center with a designated spokesman; _____

i. maintenance of security, to minimize the presence of unauthorized individuals and vehicles; _____

j. instructions on the use of elevators; and _____

k. a pre-established radio communication system for use when communications are out or overtaxed. _____

Internal disaster plan

30.69 The program shall ensure that it has fire protection services either from the local fire department or by providing its own. _____

30.70 There shall be written internal disaster and fire plans. _____

30.71 Internal disaster, fire, and evacuation drills shall be held at least quarterly for each work shift of program personnel in each separate patient-occupied building. _____

30.71.1 A written report and evaluation of all drills shall be made. _____

30.72 The program's fire plan shall provide for the following actions:

a. use of the fire alarm; _____

b. transmission of the alarm to the fire department; _____

c. steps to be taken in response to alarms; _____

d. isolation of the fire; _____

e. evacuation of the fire area; _____

f. preparing the building for evacuation; and _____

g. fire extinguishment. _____

30.73 When water is obtained from a source other than a public water supply, it shall be tested at least monthly and treated as necessary to ensure its potability. _____

30.74 Potable water supply systems shall be protected by the installation of vacuum breakers or other protective devices approved by the authority having jurisdiction. _____

30.75 There shall be a written plan for the procurement of water during an emergency. _____

30.76 All building service equipment shall be installed in accordance with applicable laws and regulations. _____

30.77 All mechanical systems in the program shall be maintained in accordance with a written preventive maintenance program, with documentation of corrective measures instituted or completed. _____

30.78 The ventilation system shall provide a controlled, filtered air supply in designated critical areas. _____

30.79 Combustion and ventilation air for boiler, incinerator, or heater rooms shall be taken from and discharged to the outside. _____

General storage areas

30.80 Storage areas, basements, attics, and stairwells shall be clean and uncluttered. _____

30.81 The spaces under stairs shall not be used for storage. _____

30.82 The lowest shelves in storage areas shall either be sealed to the floor or have sufficient space underneath to allow access for cleaning. _____

30.83 The height and arrangement of stored items shall not obstruct the proper functioning or testing of any fire detecting or extinguishing system. _____

30.83.1 A clearance of 36 inches is recommended but may be reduced to 18 inches where flammable gases or liquids are not involved. _____

30.84 The storage arrangement shall not prevent ready access to any fire extinguishing units or tools. _____

Waste disposal

30.85 Contaminated wastes shall be sealed in impervious containers at the site of origin. The containers shall be identified and kept sealed until their final disposition. _____

30.86 Waste tissue and contaminated, combustible solids shall be rendered safe by sterilization, incineration, or grinding and disposition through authorized sewage channels. _____

30.87 When trash compactors are used, they shall be located away from patient care and food preparation and serving areas, and their site shall be subject to good sanitary practices. _____

30.87.1 The compactor should have a safety circuit breaker. _____

Overall compliance: functional safety and sanitation _____

Comments and recommendations
Provide specific documentation for each 2 or 3 rating.

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_____

31. Therapeutic environment

31.1 The program shall establish an environment that enhances the positive self-image of the patient and preserves human dignity. _____

31.2 The grounds on which the program is located shall provide adequate space for the program to carry out its stated goals. _____

31.2.1 When patients' needs or the program's goals include the need for outdoor activity, areas appropriate to the ages and clinical needs of the patients shall be provided. _____

31.3 The program shall be accessible to handicapped individuals or, as an alternative, have a written plan that describes how the handicapped individuals shall gain access for necessary services. _____

31.4 Appropriate staff shall be available in any reception area or waiting room, as indicated, to meet the needs of patients and visitors. _____

31.4.1 Waiting areas shall be comfortable; and their design, location, and furnishings shall reflect a consideration of the characteristics of the patients and visitors, the anticipated length of waiting time, their needs for privacy and/or support from staff, and the goals of the program. _____

31.4.2 Rest rooms shall be available for patients and families. _____

31.4.3 A telephone shall be available for private conversations. _____

31.4.4 An adequate number of drinking units, at appropriate heights, shall be easily accessible. If drinking units employ cups, only single-use, disposable cups shall be used. _____

31.4.5 When food or beverage vending machines or other types of food service are available, there shall be policies and procedures for the efficient storage and distribution of food and beverages under safe and sanitary conditions. _____

31.4.6 Programs not having emergency medical care resources shall have first aid supplies kept in appropriate places. _____

31.4.6.1 All supervisory staff shall be familiar with the locations, contents, and use of the first aid supply kits. _____

31.5 Programs providing partial-day or 24-hour care services shall provide an environment responsive to the needs of patients. _____

31.5.1 Throughout the treatment setting, the design, structure, furnishing, and lighting of the environment shall promote clear perceptions of people and functions. _____

31.5.2 Lighting shall be under the control of the occupants of the lighted area, unless a therapeutic rationale for exclusive staff control is provided in the program's written plan. _____

31.5.3 The environment shall be designed to allow views of the outdoors. _____

31.5.4 Major areas used by patients shall have windows or skylights. _____

31.5.5 Appropriate types of mirrors, which distort as little as possible, shall be placed in appropriate places, at reasonable heights, as an aid to grooming and to enhance the patients' self-awareness. _____

31.5.6 To promote awareness of time and season, clocks and calendars should be provided in at least major use areas. _____

31.6 Ventilation shall contribute to the habitability of the environment. _____

31.6.1 Direct outside air ventilation shall be provided to each habitable room by the air conditioning system or by operable windows. _____

31.6.2 Ventilation shall be such as to remove undesirable odors. _____

31.7 All areas and surfaces shall be free of undesirable odors. _____

31.8 Door locks and other structural restraints should be used minimally. _____

31.8.1 The use of door locks or closed sections shall be approved by the clinical staff and the governing body. _____

31.9 There shall be written policies and procedures to facilitate staff-patient interaction; in particular, such policies and procedures are required when structural barriers in the therapeutic environment separate staff from the patient community. _____

31.9.1 Program personnel should respect a patient's right to privacy by knocking on the door of the patient's room before entering. _____

31.10 Areas with the following characteristics shall be available to meet the needs of patients. _____

31.10.1 Areas shall be available for a full range of social activities for all patients, from two-person conversations to group activities. _____

31.10.2 Attractively furnished areas shall be available where a patient can be alone, when this is not in conflict with a therapeutic prescription for group activities. _____

31.10.3 Attractively furnished areas shall be provided to ensure privacy for conversations with other occupants, family, or friends. _____

31.11 Furnishings and equipment shall be available to accommodate all occupants. _____

31.11.1 Furnishings shall be clean and in good repair. _____

31.11.2 Furnishings shall be appropriate for the age and physical conditions of the patients. _____

31.11.3 Repairs to broken items shall be carried out promptly. _____

31.11.4 All equipment and appliances shall be maintained in good operating order. _____

31.12 Dining areas shall be comfortable, attractive, and conducive to pleasant living. _____

31.12.1 Dining arrangements shall be based on a logical plan that meets the needs of the patients and the requirements of the program. _____

31.12.2 Dining tables should seat small groups of patients, unless other arrangements are justified on the basis of the patients' needs. _____

31.12.3 When staff members do not eat with the patients, the dining rooms shall be adequately supervised and staffed in order to provide assistance to patients when needed and to ensure that each patient receives an adequate amount and variety of food. _____

31.13 To provide privacy, sleeping areas shall have doors. _____

31.13.1 In multi-patient rooms housing more than four persons, partitioning or placement of furniture should be used to provide privacy. _____

31.13.2 The number of patients housed in multi-patient rooms shall be appropriate to the ages, developmental levels, and clinical needs of the patients and the goals of the program. _____

31.13.3 Unless written justification is made on the basis of program requirements, no more than eight patients shall be housed in each sleeping room. _____

31.13.4 Sleeping areas shall be assigned on the basis of the individual's need for group support or privacy and independence. _____

31.13.4.1 Patients who need extra sleep, whose sleep is easily disturbed, or who need greater privacy because of their age, emotional disturbance, or adjustment problems, shall have single or double bedrooms. _____

31.14 Areas shall be provided for personal hygiene. _____

31.14.1 The areas for personal hygiene shall provide privacy. _____

31.14.2 Bathrooms and toilets shall have partitions and doors. _____

31.14.3 Toilets shall have seats. _____

31.15 Good standards of personal hygiene and grooming regarding bathing, brushing teeth, care of hair and nails, and toilet habits shall be taught and maintained. _____

31.15.1 Patients shall have the personal help needed to perform these activities and shall be helped to assume responsibility for self-care as they are able. _____

31.15.2 The services of a barber and beautician shall be available to patients either within the program or in the community. _____

31.16 Appropriate to the patient's age, developmental level, and clinical status, articles for grooming and personal hygiene shall be readily available in a space reserved near the patient's sleeping area. _____

31.16.1 If clinically indicated, a patient's personal articles may be kept under lock and key by the staff. _____

31.17 Ample closet and drawer space shall be provided for the storage of personal property and property provided for the patients' use. _____

31.17.1 Lockable storage space should be provided. _____

31.18 Patients shall be allowed to keep and display personal belongings and to add personal touches to the decoration of their own rooms. _____

31.18.1 The program should establish written rules to govern the appropriateness of such decorative display. _____

31.18.2 If accessibility to potentially dangerous grooming aids or other personal articles is clinically contraindicated, the clinical staff shall explain to the patient the conditions under which the articles will be allowed, and shall document in the patient record the clinical rationale for the conditions under which the articles will be allowed. _____

31.18.3 If the hanging of pictures on walls, or other similar activities, is a privilege to be earned on the basis of the treatment program, the clinical staff shall explain to the patient the conditions under which the privilege will be granted, and shall document the treatment and granting of privileges in the patient record. _____

31.19 Patients shall be encouraged to take responsibility for maintaining their own living quarters and for other day-to-day housekeeping activities of the program, as appropriate to their clinical status. _____

31.19.1 Such responsibilities shall be clearly defined in writing and adequate staff assistance and equipment shall be provided, as needed. _____

31.19.2 Descriptions of such responsibilities shall be included in the patient orientation program. _____

31.19.3 Documentation shall be provided demonstrating that these responsibilities are an integrated part of the patient's treatment plan. _____

31.20 Patients receiving treatment shall be allowed to wear their own clothing. _____

31.20.1 If clothing is provided by the program, it shall be appropriate and shall not be dehumanizing. _____

31.20.2 Training and help in selection and proper care of clothing shall be available, as appropriate. _____

31.20.3 Clothing shall be suited to the existing climate and seasonal conditions. _____

31.20.4 Clothing shall be becoming, in good repair, of proper size, and of the character worn by the patients' peers in the community. _____

31.20.5 An adequate amount of clothing to permit laundering, cleaning, and repair shall be available. _____

31.21 A laundry room in which a patient may wash clothing should be accessible. _____

31.22 The use and location of noise-producing equipment and appliances, such as televisions, radios, and record players, shall not interfere with other activities of the therapeutic program. _____

31.23 A place and equipment for table games and individual hobbies shall be provided. _____

31.23.1 Shelves for storage of toys, equipment, and games, as indicated, shall be arranged and maintained to make them appropriately accessible. _____

31.24 Books, magazines, and arts and crafts materials shall be available in accordance with patients' recreational, cultural, and educational backgrounds and needs. _____

31.25 Live plants should be displayed indoors, and patients shall be given the opportunity to participate in their care. _____

31.26 Each program shall formulate its own policy regarding the availability and maintenance of pets and other animals, consistent with the goals of the program and with the requirements of good health and sanitation. _____

31.27 Facilities shall be available, in accordance with the size of the unit, which allow the serving of snacks and the preparation of meals for special occasions and recreational activities, e.g., baking, making popcorn or candy, and so on. These facilities shall permit patient participation. _____

31.28 Unless therapeutically contraindicated, the program shall accommodate the patients' needs for access to the outdoors through the use of nearby parks and playgrounds, adjacent countryside, and the program's grounds. _____

31.28.1 Recreational facilities and equipment shall be available, consistent with the patients' needs and the therapeutic program. _____

31.28.2 All such equipment shall be maintained in working order. _____

Overall compliance: therapeutic environment _____

Comments and recommendations

Provide specific documentation for each 2 or 3 rating.

_____

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32. Infection control

32.1 Because infections acquired in a program or brought into a program from the community are potential hazards for all persons having contact with the program, there shall be an infection control program. _____

32.1.1 Effective measures shall be developed to prevent, identify, and control infections. _____

32.1.2 A practical system for reporting, evaluating, and maintaining records of infections among patients and personnel shall be developed. _____

32.1.2.1 This system shall include assignment of responsibility for the ongoing collection and analytic review of such data, as well as for required follow-up action. _____

32.1.2.2 Corrective action based on records and reports of infections and infection potentials among patients and program personnel shall be documented. _____

32.1.3 Orientation of all new employees to the importance of infection control and personal hygiene, and to their responsibility in the program, shall be included in the infection control program. _____

32.1.3.1 Verification of inservice education relative to infection prevention and control for all services and program components shall be documented. _____

32.2 There shall be written policies and procedures pertaining to the operation of the infection control program which shall be reviewed at least annually and revised as necessary. _____

Overall compliance: infection control _____

Comments and recommendations
Provide specific documentation for each 2 or 3 rating.

_____

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_____

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_____

33. Sterile supplies and equipment

33.1 If the program utilizes sterile supplies or equipment, there shall be policies and procedures for their handling, maintenance, and use. _____

33.1.1 A department or staff member shall be designated to implement and document the implementation of these policies and procedures. _____

33.2 The policies and procedures should relate to, but not be limited to, the receiving, cleaning, disinfection, resterilization, and preparation of reusable supplies. _____

33.2.1 The policies shall relate to the assembly, wrapping, identification, storage control, and distribution of the supplies. _____

33.2.2 The policies shall relate to the monitoring of the shelf life or expiration date of such supplies and the removal from use of expired supplies. _____

33.2.3 The policies shall relate to the use, maintenance, and inspection of sterilizing equipment or sterilizing liquids or gases. _____

33.2.4 The policies shall address the acquisition of such supplies on an emergency basis when the usual dispensing unit is closed. _____

33.2.5 The policies shall relate to the emergency recall and disposition of supplies when a hazard connected with such supplies is identified. _____

33.2.6 The policies shall relate to the cleaning and sanitizing of work spaces used in the preparation of sterile supplies. _____

Overall compliance: sterile supplies and equipment _____

Comments and recommendations

Provide specific documentation for each 2 or 3 rating.

_____

_____

_____

_____

_____

_____

Appendices

Appendix A
Table of applicable standards

The following table delineates the standards that are common to all programs, regardless of service category, and those that apply to inpatient, residential, or partial-day and outpatient treatment settings. Since the intensity of the level of care provided in these settings varies, some of the applicable standards also vary. Programs should carefully review this table to determine for which standards JCAH will hold them accountable during the accreditation process.

Chapter	All programs	Institutional settings	Residential settings*	Partial-day and outpatient settings
1. Governing body†	All standards			
2. Chief executive officer†	All standards			
3. Clinical staff organization†	All standards			
4. Staff composition	All standards			
5. Personnel policies†	All standards			
6. Volunteer services†	All standards if provided			
7. Fiscal management†	All standards			
8. Referrals†	All standards			
9. Research	All standards if provided			
10. Patient rights	10.1-10.2.3, 10.2.5-10.9.4	10.2.4-10.2.4.6	10.2.4-10.2.4.6	
11. Quality assurance	All standards			

Continued on following page

*This category includes night hospitals.

†For multiple-category facilities in which the psychiatric, alcoholism, or drug abuse program is not the largest, the program will be surveyed under the standards appropriate to the largest delivery system (e.g., under the *Accreditation Manual for Hospitals*).

Chapter	All programs	Institutional settings	Residential settings*	Partial-day and outpatient settings
12. Patient records	All standards except 12.2.13, 12.5, 12.5.1	12.2.13, 12.5, 12.5.1		
13. Intake	All standards except 13.4.2c, 13.6	13.6	13.6	13.4.2c
14. Assessment	All standards except 14.2.2-14.2.4	14.2.2-14.2.2.2	14.2.3-14.2.4	14.2.3-14.2.4
15. Treatment plans	15.1-15.2.5, 15.6-15.10, 15.11-15.12.7	15.3-15.5.2, 15.10.1-15.10.3	15.3-15.3.10.2, 15.10.1-15.10.3	15.10.4
16. Activity services†		All standards	All standards	16.5-16.5.2, 16.10
17. Anesthesia services†		All standards apply when ECT and/or surgery is done		
18. Community education services	All standards if provided			
19. Consultation services	All standards if provided			
20. Dental services†	20.1, 20.1.1, 20.2-20.2.3 if the program provides such service, 20.3			
21. Dietetic services†		All standards	All standards	All standards if such service is provided
22. Educational services		22.1-22.1.3, 22.2-22.2.3 when the program provides such service, 22.3-22.5.1	22.1-22.1.3, 22.2-22.2.3 when the program provides such service, 22.3-22.5.1	
23. Outreach services	All standards if provided			

Continued on following page

*This category includes night hospitals.

†For multiple-category facilities in which the psychiatric, alcoholism, or drug abuse program is not the largest, the program will be surveyed under the standards appropriate to the largest delivery system (e.g., under the *Accreditation Manual for Hospitals*).

Chapter	All programs	Institutional settings	Residential settings*	Partial-day and outpatient settings
24. Pathology services†	24.1-24.1.3	24.2-24.2.9.2 when the program provides such service		
25. Pharmacy services†	All standards except 25.1.1-25.1.1.3	25.1.1-25.1.1.3 when the program provides such service		
26. Radiology services†	All standards except 26.2-26.2.2.2	26.2-26.2.2.2 when the program provides such service		
27. Speech and hearing services†	27.1, 27.2-27.2.5 when the program provides such service			
28. Vocational rehabilitation services	28.1, 28.2, 28.3-28.3.1.4 when the program provides such service, 28.3.2-28.3.5			
29. Building and grounds†	29.1-29.1.2, 29.1.3-29.1.5.3, 29.1.6-29.1.10	29.1.2.1, 29.1.5.4	29.1.2.2, 29.1.5.4	
30. Functional safety and sanitation†	30.1-30.2.1, 30.8	30.3-30.7, 30.9-30.10.2 and 30.29-30.44 if program does ECT or surgery, 30.11-30.28, 30.45-30.87.1	30.3-30.3.2, 30.5-30.7, 30.13-30.15.1, 30.20-30.21.1, 30.23-30.25, 30.51-30.56, 30.62-30.65, 30.69-30.81, 30.84	

Continued on following page

*This category includes night hospitals.

†For multiple-category facilities in which the psychiatric, alcoholism, or drug abuse program is not the largest, the program will be surveyed under the standards appropriate to the largest delivery system (e.g., under the *Accreditation Manual for Hospitals*).

Chapter	All programs	Institutional settings	Residential settings*	Partial-day and outpatient settings
31. Therapeutic environment	31.1, 31.2, 31.3-31.7, 31.10-31.11.4, 31.14-31.14.3, 31.22-31.25	31.2.1, 31.8-31.9.1, 31.12-31.13.4.1, 31.15-31.21, 31.26-31.28.2	31.2.1, 31.8-31.9.1, 31.12-31.13.4.1, 31.15-31.21, 31.26-31.28.2	
32. Infection control†	All standards			
33. Sterile supplies and equipment†	All standards when such supplies are used			

*This category includes night hospitals.

†For multiple-category facilities in which the psychiatric, alcoholism, or drug abuse program is not the largest, the program will be surveyed under the standards appropriate to the largest delivery system (e.g., under the *Accreditation Manual for Hospitals*).

Appendix B
Survey process questionnaire

To assess the quality of service provided by JCAH through the AP/PF survey process, the following questionnaire asks for surveyed programs' impressions of the survey process. The program is under no obligation to complete this form but is requested to do so; the answers will help to maintain and improve the quality of JCAH's services to the field. A program need not identify itself, but, if it does, the information provided shall in no way affect JCAH's accreditation decision for that program.

The chief executive officer should complete Section I, "General information," and Section II, "Survey procedures." Section III, "Surveyors," should be completed by the individual who had the most contact with each surveyor and should be completed for each surveyor who participated in the survey process.

Please return the completed questionnaire to the address below.

Survey Evaluation Unit, Accreditation Program for Psychiatric Facilities
Joint Commission on Accreditation of Hospitals
875 North Michigan Avenue, Chicago, Illinois 60611

JCAH greatly appreciates your cooperation in providing this information.

I. General information

This section should be completed by the chief executive officer.

1. How many beds does your program have?

☐ a. under 100 ☐ b. 100-500 ☐ c. over 500 ☐ d. none

2. If outpatient services are provided, what is the average daily census?

☐ a. under 25 ☐ b. 25-50 ☐ c. 51-100 ☐ d. over 100

3. In what month and year did your survey take place? _____

4. If you wish to identify your program, please complete this section.

Program name _____

Location _____ Phone _____

Signature _____ Date _____

Title _____

5. If you do not wish to identify your program, please identify the state in which it is located.

_____

II. Survey procedures

This section should be completed by the chief executive officer.

For Items 1 through 6, please rate each statement using the scale shown below. Circle the number corresponding to your rating in the column to the right of the item. Please list specific examples which led to your rating for each item; use additional sheets if necessary. (Please note that only Item 1 can be answered with "not applicable.")

Scale

0	1	2	3	4
Not applicable	Inadequate	Minimally acceptable	Satisfactory	Excellent

	Rating	Comments
1. Prior to the survey if it was necessary for you to call or write the JCAH central office, rate the extent to which JCAH staff a. cooperated with you in scheduling the survey; and	0 1 2 3 4	
b. exhibited a helpful attitude in answering your questions in preparation for the survey.	0 1 2 3 4	
2. Rate the adequacy of the length of the survey.	1 2 3 4	
3. Rate the general validity of the recommendations made by the surveyor or survey team at the summation conference.	1 2 3 4	
4. Rate the extent to which adequate feedback was presented to the program by the surveyor or survey team at the summation conference.	1 2 3 4	
5. Rate the extent to which the survey process is a valid means of evaluating compliance with JCAH standards.	1 2 3 4	
6. Rate the extent to which the survey process aids in promoting high standards of patient care.	1 2 3 4	

7. What was the most helpful or useful aspect of the survey? _____

_____

_____

8. What was the least helpful or useful aspect of the survey? _____

_____

9. If you have additional comments about the survey process, please include them here.

_____

_____

10. If the survey was part of a combined survey with another JCAH accreditation program and if you have any comments specific to the combined survey process, please include them here.

☐ part of a combined survey ☐ not part of a combined survey

_____

_____

11. Please identify any standards that you feel are inappropriate to your program and give the reason(s) why you think so.

_____

_____

12. What are your suggestions for improving this questionnaire? Are there important areas of the survey process that have not been covered that you feel are important to include?

_____

_____

13. If you wish to identify your program, please complete this section.

Program name _____

Location _____ Phone _____

Signature _____ Date _____

Title _____

14. If you do not wish to identify your program, please identify the state in which it is located.

_____

III. Surveyors

This section should be completed by the individual who had the most contact with each surveyor.

*Name of surveyor*_____

For Items 1 through 7, please rate each AP/PF surveyor participating in your survey using the scale shown below. Circle the number corresponding to your rating in the column to the right of the item. Please list specific examples which led to your rating for each item; use additional sheets if necessary. If you are unable to rate the surveyor on certain items because of a lack of information, please score 0, "no information." If more than one surveyor participated in your survey, please photocopy this form and complete one for each surveyor.

Scale

0	1	2	3	4
No information	Inadequate	Minimally acceptable	Satisfactory	Excellent

	Rating	Comments
1. Cooperativeness with program personnel and/or clinical staff in the conduct of the survey.	0 1 2 3 4	
2. Ability to support recommendations by referencing JCAH standards.	0 1 2 3 4	
3. Helpfulness in educating program personnel and/or clinical staff in JCAH standards.	0 1 2 3 4	
4. Thoroughness of the survey tour of the program.	0 1 2 3 4	
5. Consulting skills in working with program personnel and/or clinical staff.	0 1 2 3 4	
6. Consideration of the program's normal schedules.	0 1 2 3 4	
7. Clarity and specificity of summation conference presentation and recommendations.	0 1 2 3 4	

8. If you have any comments about the surveyor, please include them here. _____

_____

_____

9. On the basis of feedback from the clinical staff, was the patient records conference informative?

☐ yes ☐ no ☐ no feedback received ☐ surveyor did not participate

Comments: _____

_____

10. Were suggestions made by the clinical staff for improving the conference?

☐ yes ☐ no ☐ surveyor did not participate Comments: _____

_____

_____

11. Have you attended an AP/PF accreditation workshop educational program since your last JCAH survey or within one year before survey if this was an initial survey?

☐ yes ☐ no

12. Did the accreditation workshop provide information that was useful in meeting JCAH requirements and/or preparing for the survey?

☐ yes ☐ no ☐ not applicable Comments: _____

_____

_____

13. If you wish to identify your program, please complete this section.

Program name _____

Location _____ Phone _____

Signature _____ Date _____

Title _____

14. If you do not wish to identify your program, please identify the state in which it is located.

_____

Appendix C
Acknowledgements

The Accreditation Council for Psychiatric Facilities* is composed of the following ten Member Organizations.

American Academy of Child Psychiatry
American Association on Mental Deficiency
American Association of Psychiatric Services for Children
American Hospital Association
American Psychiatric Association
Association of Mental Health Administrators
National Association of Private Psychiatric Hospitals
National Association of State Mental Health Program Directors
National Coalition for Alcoholism Program Accreditation
National Council of Community Mental Health Centers

The affairs of the Council are governed by Councillors who are appointed by the ten Member Organizations; the Officers and Councillors are as follows.

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*As a result of the reorganization of the Joint Commission on Accreditation of Hospitals, the Accreditation Council for Psychiatric Facilities will be dissolved on June 30, 1979. The advisory function of the Council on matters concerning psychiatric, mental health, alcoholism, and drug abuse programs will be taken over by the Professional and Technical Advisory Committee for Psychiatric Facilities.

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Appendix D
Surveyor materials

With the exception of "Summary of compliance" which may be of help to a program during a self-evaluation, the following materials are for surveyor use only.

Summary of compliance

Degree of compliance legend

1—Substantial compliance 2—Partial compliance 3—Not in compliance 4—Does not apply

Program management	Surveyor(s)	First reviewer	Second reviewer
1. Governing body			
2. Chief executive officer			
3. Clinical staff organization			
4. Staff composition			
5. Personnel policies			
6. Volunteer services			
7. Fiscal management			
8. Referrals			
9. Research			
10. Patient rights			
11. Quality assurance Program evaluation			
Clinical privileges			
Professional growth and development			
Utilization review			
Individual case review			
Patient care audit			
12. Patient records			
Patient management			
13. Intake			
14. Assessment			
15. Treatment plans			

Continued on following page

Patient services	Surveyor(s)	First reviewer	Second reviewer
16. Activity services			
17. Anesthesia services			
18. Community education services (optional)			
19. Consultation services (optional)			
20. Dental services			
21. Dietetic services			
22. Educational services			
23. Outreach services (optional)			
24. Pathology services			
25. Pharmacy services			
26. Radiology services			
27. Speech and hearing services			
28. Vocational rehabilitation services			
Facility management			
29. Building and grounds			
30. Functional safety and sanitation			
31. Therapeutic environment			
32. Infection control			
33. Sterile supplies and equipment			

Patient safety

Based on the surveyor recommendations from the "Building and grounds" and "Functional safety and sanitation" sections, complete the following chart to indicate overall recommendations regarding patient safety for each patient building.

Patient building	Comments and recommendations	Overall compliance

Face sheet

Type of program
- ☐ Combined alcoholism/ drug abuse
- ☐ Alcoholism
- ☐ Drug abuse
- ☐ Child and adolescent
- ☐ Adult

Program name _____

Address _____

City _____ State _____ Zip _____ Telephone _____

Type of organization ☐ federal ☐ city ☐ hospital district ☐ private, for profit
☐ state ☐ county ☐ university ☐ private, not for profit

Head of the governing body _____

Name of governing body _____

Address _____

City _____ State _____ Zip _____

Head of the clinical staff _____

Chief executive officer _____

Surveyor(s) _____

_____

Date(s) of survey _____

For office use only

Previous history

Date _____ Result _____

Date _____ Result _____

Date _____ Result _____

Date _____ Result _____

Current survey

Date _____ Result _____

Reviewers _____

_____

Statement of Construction expiration date _____

Program profile

Program name _____

City _____ State _____

Date(s) of survey _____

Fiscal year _____ Total beds _____ Occupancy rate _____ Untoward events _____

Average daily census

	Inpatient and residential	Outpatient	Partial-day	Number of beds	Total admissions	Total discharges
Adult						
Child/adol.						
Alcohol						
Drug						
Alcohol/drug						

No. of buildings in which patients are housed overnight _____ No. of locations _____

Overhead budget $ _____ Direct service budget $ _____ Total $ _____

Program personnel

(Please include all program employees as well as clinicians who have clinical privileges to treat within the program.)

Staff composition	Full-time staff	Other staff	
		Part-time/ consultants	Total full-time equivalents*
Psychiatrists			
Child psychiatrists			
Other physicians			
Qualified psychologists			

Continued on following page

*Total full-time equivalents are determined by taking the total hours per week worked by part-time employees and consultants and dividing by 35; for example: if eight part-time psychiatrists work a cumulative total of 70 hours per week, then the total full-time equivalent is two.

Staff composition	Full-time staff	Other staff	
		Part-time/ consultants	Total full-time equivalents*
Other psychologists			
Qualified social workers			
Other social workers			
Qualified psychiatric nurses			
Registered nurses			
Licensed practical or vocational nurses			
Mental health or child care workers†			
School teachers—B.A. and above			
Activity therapists			
Vocational rehabilitation counselors			
Alcoholism counselors			
Drug counselors			
Dentists			
Pharmacists			
Qualified dietitians			
Medical records administrators			
Other professionals a.			
b.			
Other administrative/support personnel			
Total program personnel			

Prepared by _____

Position/title _____ Date _____

*Total full-time equivalents are determined by taking the total hours per week worked by part-time employees and consultants and dividing by 35; for example: if eight part-time psychiatrists work a cumulative total of 70 hours per week, then the total full-time equivalent is two.

†Includes aides, orderlies, psychiatric technicians, and other direct service personnel.

Surveyor comments

Program _____ Date(s) of survey _____

Surveyor(s) should summarize the evaluation of the program, highlighting the program's strengths as well as its weaknesses. This is of particular help to the Accreditation Committee during its review of the surveyor recommendations regarding accreditation.

Recommendation

Surveyor(s) _____ ☐ 2 years ☐ 1 year ☐ Nonaccreditation

_____

Comments

Overview of the program

_____

_____

_____

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_____

Program management

_____

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Patient management

Patient services

Facility management

Surveyor(s) signature _____ Date _____

Comments on summation conference

Comments should cover the highlights of the conference—attendance, main points of discussion, rebuttals to recommendations made by surveyor(s), and so on.

Comments on summation conference, continued

Public information interview report

Program _____ Location _____

Date held _____ Report completed by _____

Findings code

C = Confirmed
R = Rebutted
D = Disputed

Disposition code

SR = Suggested recommendation
RA = Resolved by agreement
EX = Other (include explanation)

Significant issues		Surveyor's action		
No.	Issue and informant	Findings	Disposition	Explanation

Significant issues		Surveyor's action		
No.	Issue and informant	Findings	Disposition	Explanation

Glossary

activity services Structured activities designed to help an individual develop his or her creative, physical, and social skills through participation in recreational, art, dance, drama, social, and other activities.

administrative Relates to the fiscal aspects and general management of a program rather than to direct patient services.

aftercare The process of providing continued services to a patient that support and increase the gains made during treatment.

anesthesiologist, qualified A doctor of medicine who practices the science of anesthesia, which involves the administration of a drug or gas to cause a partial or complete loss of sensations, and who is fully licensed to practice medicine in the state in which he or she practices.

AP/PF Accreditation Program for Psychiatric Facilities, Joint Commission on Accreditation of Hospitals, 875 North Michigan Avenue, Chicago, Illinois 60611.

applicant An individual who has applied for admission to a program but who has not completed the intake process.

approved Acceptable to the authority having jurisdiction.

assessment Those procedures by which a program evaluates an individual's strengths, weaknesses, problems, and needs.

audiological assessment The audiological tests for delineating the site of auditory dysfunction, including such tests as pure tone air-conduction and bone-conduction threshold, speech reception thresholds, speech discrimination measurements, impedance measurements, and others.

audiologist, qualified An individual who is certified by the American Speech and Hearing Association as clinically competent in the area of audiology or who has documented equivalent training and/or experience.

audiometric screening A process that may include such tests as pure tone air-conduction thresholds, pure tone air-conduction suprathreshold screenings, impedance measurements, or observations of reactions to auditory stimuli.

audit, financial An independent review by a public accountant certifying that a program's financial reports reflect its financial position.

audit, patient care A retrospective review of the program's services with primary emphasis on the outcomes of patient care.

authentication Proof of authority and responsibility by written signature, identifiable initials, computer key, or other method. The use of a rubber stamp signature is acceptable under the following strict conditions: the person whose signature the rubber stamp represents is the only one who has possession of the stamp and is the only one who uses it; and this person gives

the chief executive officer a signed statement that he or she is the only one who has the stamp and is the only one who will use it.

authority having jurisdiction The organization, office, or individual responsible for approving equipment, an installation, or a procedure.

bylaws The laws, rules, or regulations adopted for the government of the program. Also used for the laws, rules, or regulations of the clinical staff.

chief executive officer A job-descriptive term used to identify the individual appointed by the governing body to act on its behalf in the overall management of the program. Job titles include administrator, superintendent, director, president, vice-president, and executive vice-president.

child psychiatrist, qualified A doctor of medicine who specializes in the assessment and treatment of children and/or adolescents having psychiatric disorders and who is fully licensed to practice medicine in the state in which he or she practices. The individual shall have successfully completed training in a child psychiatry fellowship program approved by the Liaison Committee on Graduate Medical Education of the American Medical Association or have been certified in child psychiatry by the American Board of Psychiatry and Neurology, or have documented equivalent training and/or experience.

clinical privileges Authorization by the governing body to render patient care and treatment services in the program within defined limits, based upon an individual's professional qualifications, experience, competence, ability, and judgment.

clinical staff The personnel of the program who are directly involved in patient care and treatment services.

community education services The dissemination of information specifically aimed at increasing the awareness, receptivity, and sensitivity of the community to the disabilities treated by the program.

consultant An individual who provides professional advice or services upon request.

contract A formal agreement with any organization, agency, or individual, approved by the governing body, that specifies services, personnel, and/or space to be provided to or on behalf of the program and the monies to be expended in exchange.

dentist, qualified A doctor of dental science or dental surgery who is fully licensed to practice in the state in which he or she practices.

department A staff entity organized on administrative, functional, or disciplinary lines.

detoxification The systematic reduction of the amount of a toxic agent in the body or the elimination of a toxic agent from the body.

dietetic services The provision of care to meet the nutritional needs of patients with specific emphasis on special dietary needs, e.g., food allergies or the inability to accept a regular diet.

dietitian, qualified An individual who is registered by the Commission on Dietetic Registration of the American Dietetic Association or who has the documented equivalent in education, training, and experience, with evidence of relevant continuing education.

diet manual An up-to-date, organized system by which the ordering of diets standardized.

discharge The point at which the patient's active involvement with a program is terminated and the program no longer maintains active responsibility for the patient.

drug history A delineation of the drugs used by a patient, including prescribed and unprescribed drugs and alcohol, which covers but is not necessarily limited to the following: drugs used in the past; drugs used recently, especially within the preceding 48 hours; drugs of preference; frequency with which each drug is used; route of administration of each drug; drugs used in combination; dosages used; year of first use of each drug; previous occurrences of overdose, withdrawal, or adverse drug reactions; and history of previous treatment received for alcohol or drug abuse.

drugs with abuse potential Used to describe a drug that can affect the human body in such a way as to cause inordinate biological, psychological, or social harm.

electroconvulsive therapy A form of somatic treatment in which electrical current is applied to the brain producing uncoordinated muscle contraction in a convulsive manner.

emergency kit A kit designed to provide the medical supplies and pharmaceutical agents required during an emergency, the formulation of which should take into account the patients' needs for psychotropic, anticholinergic, and adrenalin agents.

external disaster A catastrophe that occurs outside of the program for which the program, based on its size, staff, and resources, must be prepared to serve the community.

facility The physical area (grounds, buildings, or portions thereof) where program functions take place that is under the direct administrative control of a program's chief executive officer.

fiscal management Procedures that provide management control of a program's overall financial and general operations. Such procedures may include cost accounting, program budgeting, materials purchasing, and patient billing.

formulary A catalog of the pharmaceuticals approved for use in a program which lists the names of the drugs and information regarding dosage, contraindications, and unit dispensing size.

fundamental needs The physical, psychological, chronological age, developmental, family, educational, social, environmental, and recreational needs of patients.

governing body The person or persons with ultimate authority and responsibility for the overall operation of the program.

guardian A parent, trustee, committee, conservator, or other person or agency empowered by law to act on behalf of or have responsibility for an applicant or patient.

hazardous area Any area in which highly combustible, highly flammable, or explosive products or in which materials likely to burn with extreme rapidity or produce poisonous fumes or gases are used. For clarification see the 1973 edition of the *Life Safety Code,* NFPA 101.

hazardous procedures Procedures that place the patient at physical or psychological risk or in pain.

human subject research The systematic study, observation, or evaluation of factors related to the prevention, assessment, treatment, and understanding

of an illness which requires the participation of patients receiving services. This involves all behavioral and medical experimental research that involves human beings as experimental subjects.

incident report A written report initiated by a patient or staff member of a program which documents unusual incidents, problems, conflicts, or any other situation for which the patient or staff member wishes to have follow-up action taken by appropriate program administrative or supervisory personnel.

individual case review A procedure for monitoring a patient's progress that is designed to ensure the adequacy and appropriateness of the services provided to that patient.

inpatient care The process of providing care to persons who require 24-hour supervision in a hospital, residential facility, or other suitably equipped setting.

intake The administrative and assessment process for admission to a program.

JCAH Joint Commission on Accreditation of Hospitals, 875 North Michigan Avenue, Chicago, Illinois 60611.

listed Used to indicate equipment or materials included in a list published by a nationally recognized testing laboratory, inspection agency, or other organization concerned with product evaluation which maintains periodic inspection of production of listed equipment or materials and whose listing states either that the equipment or material meets nationally recognized standards or has been tested and found suitable for use in a specified manner.

may Used to reflect an acceptable method of compliance with a standard that is recognized but not preferred. See *shall* and *should.*

multidisciplinary team A group of clinical staff members that is drawn from or represents different professions, disciplines, or service areas.

NFPA National Fire Protection Association, 470 Atlantic Avenue, Boston, Massachusetts 02210.

nurse A person who is licensed and registered to practice nursing in the state where he or she practices.

nurse, practical A person who is licensed or registered as a practical or vocational nurse in the state where he or she practices.

nurse, psychiatric, qualified A licensed nurse who has a master's degree in nursing, or who has been certified to practice psychiatric nursing by the voluntary certification process of the American Nurses Association, or who has the documented equivalent in training and/or experience.

outpatient care The process of providing diagnostic and treatment services in a nonresidential setting.

outreach The process of systematically interacting with the community for the purposes of identifying persons in need of services, alerting persons and their families to the availability of services, locating needed services, and enabling persons to enter the service delivery system.

parenteral product Sterile, pharmaceutical preparations ingested by the body through a route other than the alimentary canal.

partial-day care The process of providing treatment services that are designed for patients who spend only a part of a 24-hour period in the program (e.g., day hospitals and night hospitals).

patient Term used for an individual who receives treatment services. Patient is synonymous with client, resident, consumer, and recipient of treatment services.

personnel record The complete employment record of a staff member or employee, including job application, education and employment history, performance evaluations, and licensure where applicable.

pharmacist An individual with a degree in pharmacy who is licensed and registered to prepare, preserve, compound, and dispense drugs and chemicals in the state in which he or she practices.

physician, qualified A doctor of medicine or doctor of osteopathy who is fully licensed to practice medicine in the state in which he or she practices.

program A general term for an organized system of services designed to address the treatment needs of patients. Program is synonymous with facility, agency, unit, and organization.

program evaluation The management component of a program which has as its objective the determination of the degree to which a program is meeting its stated goals and objectives.

psychiatrist, qualified A doctor of medicine who specializes in the assessment and treatment of individuals having psychiatric disorders and who is fully licensed to practice medicine in the state in which he or she practices.

psychologist, qualified An individual who has a doctoral degree in clinical psychology from a training program approved by the American Psychological Association; or who has been certified in the appropriate specialty by the American Board of Professional Psychology; or who has been licensed or certified by a state examining board; or who has been endorsed by the state psychological association through voluntary certification; or who is listed in the National Health Registry for Psychologists; or who has the documented equivalent in training and/or experience.

restraint Any pharmaceutical agent or physical or mechanical device used to restrict the movement of a patient or the movement of a portion of a patient's body.

seclusion A procedure that isolates the patient.

service Used to indicate a functional division of a program or of the clinical staff. Also used to indicate the delivery of care.

shall Used to indicate a mandatory standard.

should Used in a standard to indicate the commonly accepted method of compliance.

social assessment The process of evaluating each patient's environment, religious background, childhood history, military service history, financial status, reasons for seeking treatment, and other pertinent information that may contribute to the development of the individualized treatment plan.

social worker, qualified An individual with a master's degree from an institution accredited by the Council on Social Work Education, or who has been certified by the Academy of Certified Social Workers, or who has the documented equivalent in training and/or experience.

speech screening A process that may include such tests as articulation in connected speech and formal testing situations; voice in terms of judgments of

pitch, intensity, and quality and determinations of appropriate vocal hygiene; and fluency, usually measured in terms of frequency and severity of stuttering or dysfluency (based upon evaluation of speech flow-sequence, duration, rhythm, rate, and fluency).

support staff Employees or volunteers of a program whose primary work activities involve clerical, housekeeping, security, laboratory, record keeping, and other functions necessary for the overall clinical and administrative operation of the program.

transfer Movement of a patient from one treatment service or location to another.

utilization review The process of using predefined criteria to evaluate the necessity and appropriateness of allocated services and resources to ensure that the program's services are necessary, cost efficient, and effectively utilized.

vocational assessment The process of evaluating each patient's past experiences and attitudes toward work, present motivations or areas of interest, and possibilities of future education, training, and/or employment.

Index

Attachment B
RCH

Governor's Task Force on SRS

Task Force Members:

Robert C. Caldwell
David B. Dallam
Joe Greve
Corrine J. Gutierrez
Arno F. Knapper, Chairman
Janet D. Leick
Naomi B. Lynn
Billy Q. McCray
John Mendoza
Beth Sheffel
Darlene Stearns
Marjorie Lee Taylor
Joseph A. Thompson
George D. Vega
Fred Weaver

final report to the Governor

STATE OF KANSAS

OFFICE OF THE GOVERNOR
State Capitol
Topeka 66612

n Carlin *Governor*

August 3, 1979

The Honorable John Carlin
Governor of Kansas
State Capitol
Topeka, Kansas 66612

Dear Governor Carlin:

Pursuant to your letter to me of March 1, 1979, the Task Force to Review the State Department of Social and Rehabilitation Services was formed to consider the basic questions presented in your letter. The Task Force has concluded its hearings and deliberations and has prepared the accompanying report concerning its conclusions and recommendations.

The members of the Task Force were Robert C. Caldwell; David B. Dallam; Joe Greve; Corrine J. Gutierrez; Arno F. Knapper, Chairman; Janet D. Leick; Naomi B. Lynn; Billy Q. McCray; John Mendoza; Beth Sheffel; Darlene Stearns; Marjorie Lee Taylor; Joseph A. Thompson; and George D. Vega. Representative Fred Weaver was represented by his legislative aide, Linda Junk, at the hearings. Charlene Satzler served superbly as recording secretary and Ruth C. Dickinson, from the Division of State Planning and Research, Department of Administration, and Christopher Smith, of the Department of Social and Rehabilitation Services served as excellent resource people.

The first two meetings, March 23 and April 6, were devoted to learning about the functions and structure of the Department of Social and Rehabilitation Services. Secretary Harder was the principal witness to appear before the Task Force on those days to describe the Department and to answer questions from Task Force members. Meetings held on April 20, May 4, May 18, June 8, and June 22 were open hearings for anyone wishing to appear before the Task Force. On June 29 five members of the Task Force held open hearings at Scott City, Kansas, for the convenience of citizens living in the western part of the state. July 13 and 20 and August 3 were spent in Task Force deliberation and in preparation of this report.

People who appeared before the Task Force were asked to present written statements prior to their appearances so that the Task Force could read their statements and thereby be prepared to engage in better informed and more fruitful discussions. Although not all those appearing presented written statements prior to the meetings, nearly everyone presented a written statement either before, at, or following their appearances. A few people presented written statements but did not appear.

Summary of Recommendations

1. Retain umbrella concept but restructure line and staff functions.
2. Elevate Equal Employment Officer.
3. Restructure Executive Committee.
4. Appoint a statewide monitoring committee.
5. Appoint an ombudsman for external grievances.
6. Inventory advisory groups.
7. Recognize Secretary and Division Heads as advocates for programs and clients.
8. Increase responsibility of Division Heads.
9. Reevaluate and strengthen personnel management programs.
10. Continue efforts to simplify technology and procedures.

All people appearing before the Task Force were asked to present oral summary statements, which were followed by an exchange of questions and answers. Although a number of participants were concerned that they would have insufficient time for their presentations, everyone was given an opportunity to make additional comments upon conclusion of the discussions. As a result, all participants were accorded whatever time they wished to make relevant and meaningful statements.

Accompanying this report are copies of all written statements, minutes of the Task Force meetings, tape recordings of those meetings, unsolicited letters directed to the Task Force, as well as other relevant documents presented to the Task Force.

The Task Force appreciates the contributions made by all participants who appeared before it as well as the contributions of those who sent statements or letters but were unable to attend. The Task Force recognizes that many of the participants in the hearings did so at their own personal expense and in some cases at considerable personal inconvenience. To those people in particular, the Task Force offers its sincere thanks and appreciation.

The Task Force considers its mission completed and its duties discharged. If you would like to meet with the Task Force for discussion of the report, we will be pleased to do so.

Sincerely,

Arno F. Knapper, Chairman
Task Force on Review of the
Department of Social and Rehabilitation
Services

AFK:ssg

Enclosures

A Report

on the

State Department of Social and Rehabilitation Services

This report addresses the five basic questions enumerated in Governor Carlin's letter of March 1, 1979, to each member of the Task Force. Those questions are as follows:

1. What kind of structure can best insure service integration, visibility for program areas, accountability, and responsiveness to the public?
2. Does SRS effectively meet the stated goals of the agency?
3. In what ways does and should SRS respond to citizen input?
4. Is the agency in a position to promote services for people while at the same time be responsive to the demands placed upon the agency within the public sector?
5. How does an organization, like SRS, handle the question of advocacy on the part of the client groups and/or provider groups being served by SRS?

In addition to those questions, the Task Force was prompted by repeated testimony at the hearings to address two additional issues. The first of these two issues was the general topic of the personnel of the Department of Social and Rehabilitation Services. The second topic was the technology and procedures used by the Department in the performance of its mission.

Since all of these issues are broad in scope and since the Task Force was limited in the amount of time and resources available to devote to the entire task, conclusions and recommendations necessarily reflect such limitations. Most of the issues are closely interrelated; consequently, conclusions and recommendations necessarily exhibit interdependence. As a result, some of the recommendations of the Task Force lack the specificity that may, on the surface, appear desirable. In such cases, the recommendations reflect not only the interdependence and complexity of the situation but also the need for additional study and analysis.

The recommendations of this study are the result of the collective and deliberative judgments of the Task Force. The report is not a tabulation of facts and opinions, nor is it the result of a scientific or systematic procedure designed to produce a complete and balanced representation of what exists. Conversely, given the time and resource limitations, the Task Force heard many facts, many opinions, and many strong feelings from individuals having special interests and in some cases, perhaps, axes to grind.

In its deliberations the Task Force considered the facts, weighed the evidence, applied its own special knowledges, and made its judgments. The recommendations, therefore, are the considered opinions of 15 interested and concerned citizens.

Conclusions and Recommendations

Structure of SRS

There is no precise formula for the organization of state human services delivery, but over thirty states have combined umbrella agencies with a single administrator reporting to the governor. Beyond the federal impetus to administer income maintenance and social services through a single state agency, states prefer to combine human services programs to eliminate overlapping and duplication among agencies which are often aimed at serving the same clients and to increase management control. Such consolidation can increase service integration, make the combined agencies more accountable to the state's chief executive and the public, and eliminate wasteful rivalries among professional groups. Most states have found that the umbrella structure lends itself to the integration of policies and operations, and the Task Force believes that the umbrella concept is the most practical and viable organizational principle for the delivery of social and rehabilitative services in Kansa.

However, there are potential hazards if the system is not carefully managed and monitored. Its size alone presents a challenge to service integration and coordination. Its vastness makes possible a breakdown in communication and an absence of a clear

understanding of exactly to whom its employees are accountable. The clients of SRS can become alienated when individuals perceive a lack of empathy and responsiveness on the part of the bureaucracy and are unable to find clear avenues of appeal. A great deal of the testimony heard by the committee deals specifically with these problem areas and suggests that the Department of Social and Rehabilitation Services is vulnerable in these areas. These weaknesses have in some instances manifested themselves in ways that have impeded delivery of services. These problems are not necessarily inherent in large bureaucracies; rather, they are challenges that can be met through an effective management system and through some basic restructuring of the present organization.

1. The Task Force recommends the retention of the umbrella concept with the following functional divisions within the Department of Social and Rehabilitation Services:

   a. The Division of Mental Health and Retardation Services;

   b. The Division of Children, Youth, and Adults;

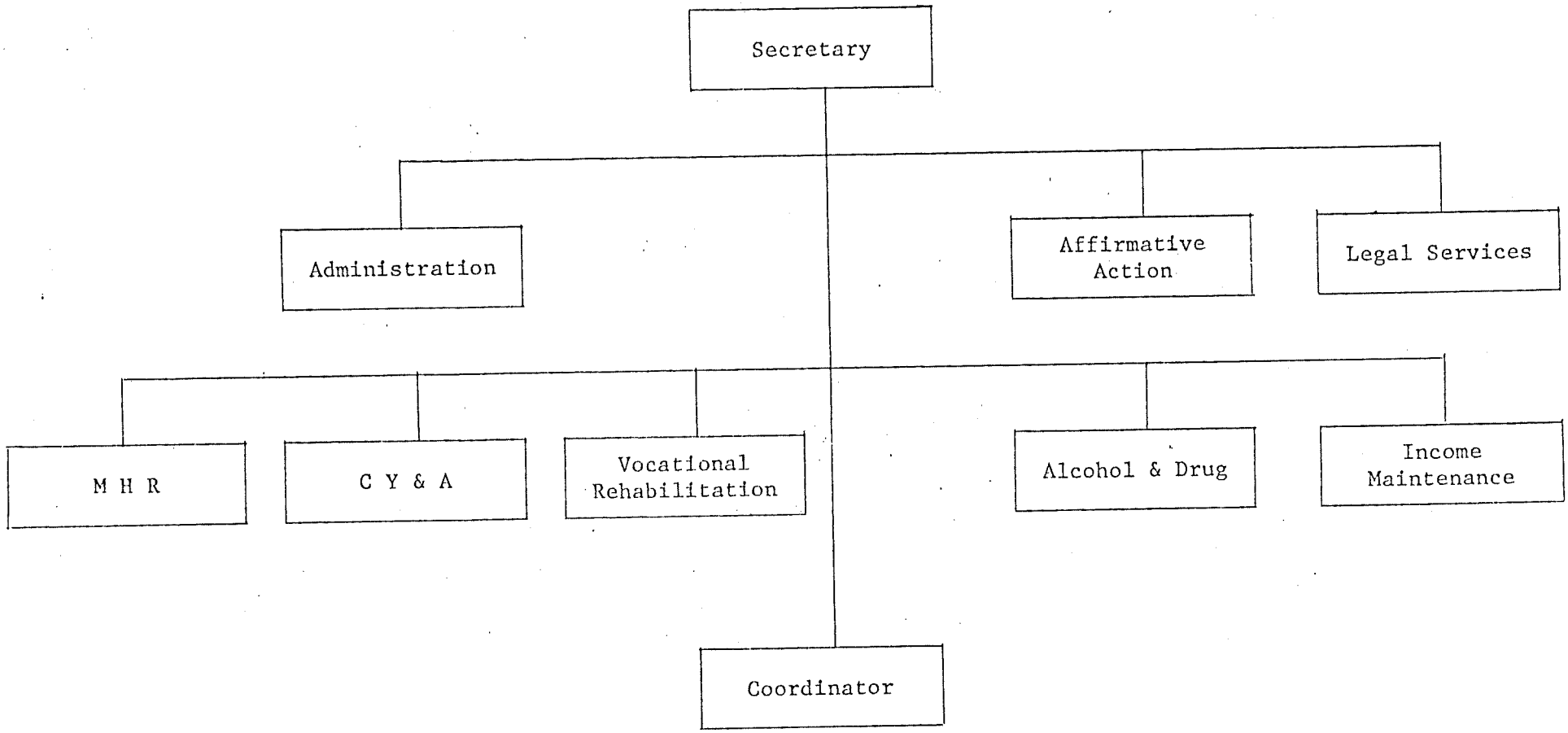
   c. The Division of Vocational Rehabilitation;

   d. The Division of Alcohol and Drug Abuse; and

   e. The Division of Income Maintenance.

   The suggested organizational structure (illustrated on Page 4) is intended to assist the Secretary in the overall management of the Department and thereby improve the benefits to be derived from the umbrella concept. Specifically, the proposed structure narrows the span of control, which should facilitate communication both vertically and horizontally. Such improvement in communication will provide for better program coordination and timely decision making by program managers. The more explicit lines of authority and responsibility should also minimize organizational conflict that often occurs in large organizations.

SRS



Notes: Administration, Affirmative Action, and Legal Services are staff functions that serve all parts of SRS. Mental Health and Retardation; Children, Youth, and Adults; Vocational Rehabilitation; Alcohol and Drug; Income Maintenance; and Coordinator of Area Offices are line functions that pursue the various missions of SRS.

The E utive Committee should consist of the Secretary, the five division heads, the three staff ' ads, and the Coordinator of Area Offices who should serve ex officio.

A significant majority of the decisions emanating from SRS appears to be raised to the level of the Secretary. Many public administrators believe that the lower the level at which decisions are made, the greater is the vitality of management and the speed with which problems will be solved. According to this view, administration is more a matter of cooperation than it is of authority; consequently, roles must be defined and decisions made at all levels in the hierarchy.

Such improvements in the SRS organizational structure will not only have direct benefit to clients in the improved response time in meeting their needs but should also aid in providing the range of services needed.

2. Currently the Equal Employment Opportunity officer reports to the Chief of Operations who reports to the Director of Administrative Services who in turn reports to the Secretary of SRS. This position should be placed directly under the supervision and control of the Secretary. Studies indicate that, for affirmative action programs to be successful, middle management must perceive top management's commitment to affirmative action goals; mere lip service will not suffice. One effective way to convey this commitment is structurally, by placing the affirmative action officer as close to top management as possible. In this way, when the Equal Employment Opportunity officer speaks, it is the voice of the Secretary that is heard. It is through this EEO function that SRS can address concerns for qualified staff with the skills necessary to assist specific client groups, such as Hispanics in Western Kansas.

3. To facilitate the work of the area offices and to reduce the number of people reporting directly to the Secretary, a Coordinator of Area Offices should be created.

Coordination is the active agent of administration. Performance of the total Department depends as much on the linkages involved in the total operation as it does on the productivity of each component division. The role of the Coordinator of Area Offices is to facilitate, synthesize and synchronize, not to function as a program director.

4. To recognize the uniqueness of its programs, its system of delivery, and its funding, a new division of Alcohol and Drug Abuse should be created.
5. The Executive Committee should be comprised of the Secretary of SRS and the five division directors. The heads of Administration, Equal Employment Opportunity, and Legal Services and the Coordinator of Area Offices should serve as nonvoting, ex officio members of the executive committee. This executive committee should hold regular and frequent meetings to permit the free exchange of ideas and expression of program needs.

The suggestions for reorganization are limited to those at the top level. Testimony indicates that there are other organizational weaknesses at the lower levels. The Task Force recommends that Divisions make an internal structural study and consider lower level reorganization.

By retaining the existing umbrella concept for the Department of Social and Rehabilitation Services, these recommendations continue to enable the Department to provide for the integration of social services (both state operated and community operated) with institutional, vocational rehabilitation, and income maintenance services. Certain improvements in integration of services need to be made but must be accomplished through strengthened training programs and improved case management systems at the lower levels of organization.

The revised organizational chart makes visible to the public and provider group the divisions (and division heads) responsible for specific program areas. It eliminates the Divisions of Social Services and of Children and Youth as separate entities. Although these divisions are individually mentioned in the statutes, they do not function separately at present, and in combined form, they are also responsible for providing adult services.

Meeting of Goals

"The spirit of cooperative action -- of giving our neighbor in need a helping hand" is the touchstone of the Department of Social and Rehabilitation Services.

The ultimate goal of SRS is to ensure that each citizen has access to economic, social, mental, or physical assistance, if needed, to assist that citizen in "the realization of his (her) full ability to be a contributing member of society."

It is clear that SRS has been striving to meet that goal. To what extent SRS should extend a "helping hand" and the measure of its success are matters of individual opinion, personal dilemma, social philosophy, budgetary feasibility, and organizational structure.

The Task Force, therefore, questioned whether the organizational structure of SRS helped or hindered the meeting of goals and found no conclusive evidence that the structure is a hindrance to the meeting of goals. Conversely, an umbrella structure does much to help meet goals.

There are, however, evidences of the need to improve administrative practice, organizational effectiveness, and personal behavior to help facilitate the meeting of goals. These factors are addressed under other sectional topics of this report.

Citizen Input

A recurring theme in the public hearings related to what appeared to be the Department's lack of responsiveness to citizen input. This was evidenced in a number of ways -- failure to involve informed and interested groups sufficiently in program planning, seeming rejection of proffered ideas without explanation, and what was perceived as brusque treatment of interested citizens and providers of service.

1. The Task Force recommends the appointment of a statewide monitoring committee with direct advisory responsibilities to the Governor. Since fragmentation is an inherent problem in the comprehension of many diverse services under one umbrella, a statewide monitoring committee seems

advisable. Such a committee could be in the position to help with problems of a regional or statewide nature. Although the committee would report to the Governor, it would share its findings and recommendations with the Secretary of SRS.

There would need to be a clear understanding and acceptance of the specific role of this committee. There would need to be a serious commitment on the part of committee members to make carefully studied and responsible recommendations. There would need to be a commitment on the part of government officials to provide the committee with the financial resources and political support necessary to make it an effective body. The committee must be prepared for rejection of its ideas by the Governor and the Secretary, from time to time, but it is extremely important that well spelled-out reasons for the rejections be given. The state's history is strewn with the graves of so-called advisory committees attenuated into oblivion by confusion as to purpose and indifferent treatment by government officials.

Selection of a statewide monitoring committee would not be easy if it is to be an effective committee. It would be vital to find people who are truly dedicated and unbiased, willing to serve, and sincerely interested in the programs of the agency. Extensive knowledge of program details or technical expertise would be less important than the qualities just mentioned.

A considerable value of this committee could be its role as a sounding board for the Governor and the Secretary. Credibility of the committee would be enhanced if the selection of members is carefully made to avoid vested interests.

The committee could work out its own mechanism for keeping in touch with what is going on throughout the state, but there should be periodic public hearings in various regions and occasional meetings with advisory committees and advocacy groups of particular programs and services.

2. An ombudsman system for both clients and service providers should be created in the interest of reducing wasteful confusions, frustrations, and inequities.

Currently there seems to be an absence of any clear-cut mechansim for the handling of misunderstandings and problems arising between citizens and agency personnel. Many difficulties appear to be resolved only after a considerable waste of time and effort on everyone's part.

The establishment of an ombudsman system could be a helpful mechanism for dealing with problems before the unresolved tensions develop a head of steam difficult to dissolve. An ombudsman system for clients (and other citizens) could help in interpreting policies, in answering questions, in clarifying work assignments, in helping to prevent unnecessary and time-consuming crises, and by identifying areas in which personnel need training and development. The ombudsman should be an independent position not accountable to the Secretary of SRS. One alternative would be to have the ombudsman report to the monitoring committee discussed above.

3. Although there are citizen advisory groups connected to various SRS programs, it is not clear what their specific functions are, how much attention is paid to their recommendations, and whether the advisory groups themselves are clear about their precise purposes. An inventory of these advisory groups and their functions would be valuable in clarifying how these bodies should function and what changes are needed in their purposes and structure.

In the development of state plans for various programs as, for example, alcohol and drug abuse, there appears to have been inadequate consultation with informed citizen groups. Involving such citizens fully in the planning may be time consuming and enervating. Nevertheless, a systematic and

persistent effort along these lines can produce a more effective plan. Moreover, such involvement can help keep citizen groups better informed about the realities of the agency and its operations. Indeed, efforts at communication between citizens and the agency can help reduce the number of unrealistic expectations (and, therefore, frustrations) that stalked like shadows over some of the public testimony.

Service vs. Public Demand

Each citizen of the state is entitled to receive what the law provides any citizen under the circumstances of a particular situation. Since the law is to be duly promulgated and since SRS is the legal designee for carrying out the provisions of the law, the Department must make known to the citizens of the state the services that are available and must be prepared to render those services to all who are entitled to them. On the other hand, SRS should not be compelled to force services upon citizens simply because they are entitled to them. In pursuit of those responsibilities, the Department should maintain a policy of economic frugality.

Advocacy

Since the employees of SRS are selected not only for their technical competence but also for their substantive knowledge about the social and rehabilitative services, those employees are an invaluable source (perhaps the best source) of factual and judgmental information. Also, the employees are expected to carry out their responsibilities toward meeting the goals of the Department. Therefore, by definition, the employees of SRS must serve as advocates for clients and programs.

1. The line division heads must be recognized and be held responsible as prime advocates for SRS programs and clients.

   Since the division heads carry responsibility for prime advocacy for their divisions, they should be strong people who are responsive to innovation and purposive change and committed to meeting the needs of the citizens of the

state. Their job descriptions should reflect such qualifications and must include the tasks of long-range planning and policy formulation. Division heads should share the responsibility for advocating for programs and clients and appear with the Secretary at budget hearings and at meetings with the Governor and the Legislature to explain their programs.

2. Testimony before the Task Force revealed the strong opinion that provider groups and client groups should have strong advocates within the SRS structure. Unfortunately, the views expressed often reflected a desire for advocacy for narrow and special interests. It would be impossible to comply with all requests without jeopardizing the needs of some of the other clients served by SRS. These groups must understand that although their advice is needed and should be actively solicited, the Secretary and division heads cannot be advocates for all causes. Instead, they must make decisions on which programs to promote based on priorities determined by what is best for the total program and the realities of limited financial resources.

Personnel

The Task Force heard testimony from clients, provider groups, employees and interested citizens; in each case it seemed there was some reference made to SRS staff's performance of duties. Citizens, clients, and providers reported mixed responses about employees. Some were highly complimentary while others were extremely critical about individuals and/or employees in general. Such mixed reactions should be expected when dealing with highly diversified activities involving emotional stress and economic strain. In SRS, perhaps more so than in many other agencies, great attention should be placed on the need for proper selection, placement, training, and performance evaluation of employees.

The Task Force review revealed some weaknesses in the area of personnel management. The Task Force recommends a complete reevaluation of present personnel management programs and a strengthening of efforts to recruit, select, place, train, and evaluate personnel. This evaluation should include personnel at all levels of the organization.

The following areas are not exhaustive but are illustrative of the Task Force's concerns for apparent personnel problem areas where reevaluation is necessary or where greater efforts are needed:

1. Recruitment. SRS should develop a more aggressive affirmative action program to recruit and employ numbers of minority groups and the handicapped, particularly for jobs of responsibility at policymaking levels.

   The Task Force believes (as shown on the suggested organizational chart) that the affirmative action (EEO) officer should be elevated to a position of greater importance within the agency. The Secretary should make clear that he supports and is committed to the agency's affirmative action plan. Immediately, the agency should develop a plan to recruit, hire, train, promote, and retain members of minority groups in those offices and facilities where there is frequent contact with those groups of clients SRS serves.

   The Task Force believes that SRS should be a model among state organizations with its affirmative action program. Certainly the goal should go well beyond merely satisfying minimum standards.

2. Training and Development. The training and development of employees is a continuous process and should exist throughout the entire organization. Toward that end:

   a. Management training must be required for each SRS employee in a management-level position. Each person should receive training both in the management of people and in the substantive content of programs.

Such training will increase competence at all levels of management. It will also enable high-level management to devote more of its time and effort to policymaking and long-range planning and to devote less time and effort to the routine details of daily operations.

b. Each person supervising employees must be required to participate in and satisfactorily complete a comprehensive supervisory training program.

c. Each new employee -- and those moving into new jobs -- should be trained to perform the assigned task well. Those employees who meet the public in their jobs should also receive special training sensitizing them to the needs of SRS clients. Before being appointed to any position within SRS, the applicant should be evaluated on the basis of that individual's understanding and commitment to the philosophy inherent in the delivery of social and rehabilitation services.

d. Of great concern to the Task Force was the apparent lack of awareness of some employees about programs and community resources that are available to SRS clients. The "umbrella" concept is designed, according to the SRS Annual Report, to "deliver a full range or continuum of social and support services with speed and efficiency across the state." Outside community services are also important to the client, and SRS employees should know the programs offered. SRS employees should be made aware through training how their work fits into the total picture of social services available to community citizens.

To improve services to clients with multiple problems, methods should be worked out for maximum cooperation among workers of various programs. For example, when such a client is assigned several caseworkers, they should have regular group meetings to determine ways to help the client. One member of the caseworker group should then be assigned the primary responsibility for maintaining a sustaining working relationship with a particular client.

e. In-service training should be used to bring employees up-to-date on changing procedures and policies, new programs, and changing techniques. Motivation training might also be used to resensitize the employee who may suffer from work fatigue or "burn-out," a highly likely occupational hazard of social workers, aides, and others who work directly with clients.

f. SRS training programs should be generally uniform across the state. Although training programs exist at the mental health and retardation institutions, the direction and effectiveness of those programs should be orchestrated by the central Administrative Services Division. Uniform training programs should be developed for similar jobs across the state.

g. An effort should be made to train employees to allow for some flexibility in SRS programs and procedures when the need arises. The employee should, however, continue to work toward the intent of the regulations and program guidelines.

h. Employees need opportunities to improve their job status within the SRS organization. This seemed particularly true for workers within the Division of Income Maintenance. SRS must find a way to provide its employees with opportunities for job advancement if the Department is to retain employees and benefit from their training. A current complaint is that a social worker needs to leave the field and go into administration to advance.

i. There appears to be a reluctance, sometimes even fear, by SRS employees to express their opinions and suggestions for solutions to agency problems.

(1) The administrative style of the Department appears to be one of discouraging substantive input from employees at the entry and supervisory levels as well as from clients.

(2) There appeared to be little communication from front-line employees to central administration. Instead, the communication appears mostly to run from top to bottom, resulting in a stultification of the relationship between workers and central administration.

3. Performance Appraisal. Job descriptions of all positions in SRS should be reevaluated to determine whether the descriptions are current and whether the descriptions indeed describe the jobs appropriately. The descriptions should state clearly not only the specific tasks to be done but also the attitudes needed for properly fulfilling the jobs as well as the public impressions and working atmospheres needed to be created by employees in their jobs.

Some fairly minor decisions appear to be made rather high up in the organization. Job descriptions should be written to reflect the levels at which various types of decisions should be made; the descriptions should clearly specify the authority and pinpoint the responsibility for decision making. As a general principle, decisions should be made as close to the level of implementation as is possible.

A number of providers appearing before the Task Force made such statements as "I was treated as if I were a client" or "I was made to feel inferior." The Task Force believes that everyone is entitled to courteous and respectful treatment, that no one should be made to feel inferior or ever apologetic, and that everyone's dignity should be fully respected. These qualities of employee performance should be specifically appraised at the time of regular evaluations.

The present evaluation forms should be discarded and replaced with forms more descriptive and fully relevant to the tasks of the jobs. Both supervisors and workers should take part in constructing new job descriptions and evaluation forms.

4. Grievance Procedures. Although every employee should have the right to appeal decisions through the normal chain of command, modern organizational structures often provide for a system of consultation separate from the chain of command.

The Task Force perceived a feeling among employees that they were often stifled in their attempts to make suggestions, to appeal decisions, to have their grievances heard, or simply to communicate upward in the organization. A personnel counselor, whose door is always open, could serve as a sounding board to the employee and assist in solving problems.

Technology and Procedures

What may appear to an SRS employee as obvious and routine may appear to a client as obscure and unusual. Also what may appear relevant and essential to an employee may appear irrelevant and unnecessary to a client. Thus, the conditions for disagreement and conflict between the two are created. Many clients are critical of SRS forms and procedures because they do not see the relevancy or applicability to them. Many clients simply cannot comprehend the complexity of some of the simplest directions and instructions. Many clients feel so overwhelmed by the many forms presented to them that they tend either to ignore them or to become intimidated and fearful of doing something wrong as a result of threatened penalties if something is not done properly and promptly.

The Department of Social and Rehabilitation Services should place continuing emphasis upon:

1. The improvement and simplification of technology and procedures;
2. The reduction to a minimum of duplication of data and the repetition of information; and
3. The dissemination of accurate information to area offices systematically and promptly.

In this way, the best interests of the Department of Social and Rehabilitation Services, the Department employee, and the client ultimately will be served.

attachment c

STATE OF KANSAS

JOHN CARLIN, GOVERNOR

STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

December 10, 1979

ROBERT C. HARDER, SECRETARY

STATE OFFICE BUILDING
TOPEKA, KANSAS 66612

SRS Progress Report

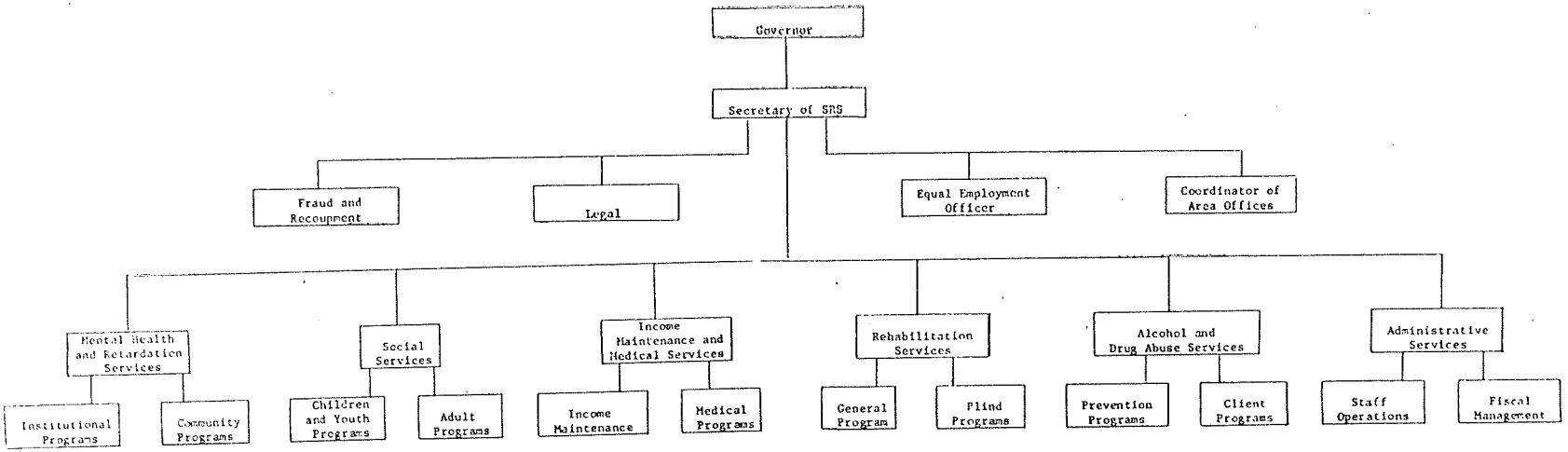
Implementation of SRS Task Force Recommendations

Task Force Recommendations	Governor's Initiative	SRS Action
1. Retain SRS umbrella concept	Agreed	Ongoing
2. Clarify lines of authority	Recommending executive order	Ready to implement
3. Develop new organizational chart simplifying central office structure	Agreed	Accomplished
4. Elevate the Equal Employment Opportunity Officer to the Office of the Secretary	Agreed	Accomplished
5. Create a Coordinator of Area Offices	Agreed	An acting coordinator has been appointed
6. Elevate the Alcohol and Drug Section to Division status	Agreed	Accomplished
7. The division directors should make up the executive committee	Agreed with modifications. Decision making in SRS should involve more than six persons.	Implemented an expanded executive committee with division directors serving as steering committee
8. Eliminate two separate divisions of social services and children, youth and adults	Agreed	Accomplished by separating out unique work and setting that forth on organizational chart
Appoint a statewide monitoring committee	Agreed to concept but recommended that SRS appoint at least one committee (and two, if feasible and appropriate) to each major program area, review role and function of committees	a. MH/RS, on-going b. C&Y, on-going c. Medical, on-going d. VR, on-going e. Blind, on-going f. A&D, on-going g. Others, in process

Task Force Recommendations	Governor's Initiative	SRS Action
10. Each division review its internal structure and study each job description as appropriate	Agreed	Ongoing
11. Review of personnel practices	Agreed	Ongoing
12. Training be more geared to client responsiveness	Agreed	Training sessions are being developed
13. Establish ombudsman	Holding for further review in light of constituent services in governor's office and complaint system in SRS	Refinement of current SRS system
14. Provide a mechanism for employee input	Agreed	Requesting a personnel counselor
15. Division directors job specifications should include an advocacy and planning role	Agreed	Implementing
16. Greater awareness on the part of local offices in relation to total community resources	Agreed	Calling upon each area office/ state facility to expand outreach into communities
17. Staff training should include teaching related to positive attitudes in serving the public	Agreed	Training is ongoing
18. Grievance procedures should be reviewed	Agreed	An SRS committee is working on this matter
19. Forms should be reviewed with the hope of eliminating forms	Agreed	An SRS committee is working on this concern on an ongoing basis
20. Greater utilization of computer technology	Agreed	Computer technology being expanded to area offices and state institutions

Submitted by
Robert C. Harder, Secretary
Social and Rehabilitation Services
December 10, 1979

D R A F T



October 30, 1979

D R A F T

Attachment D

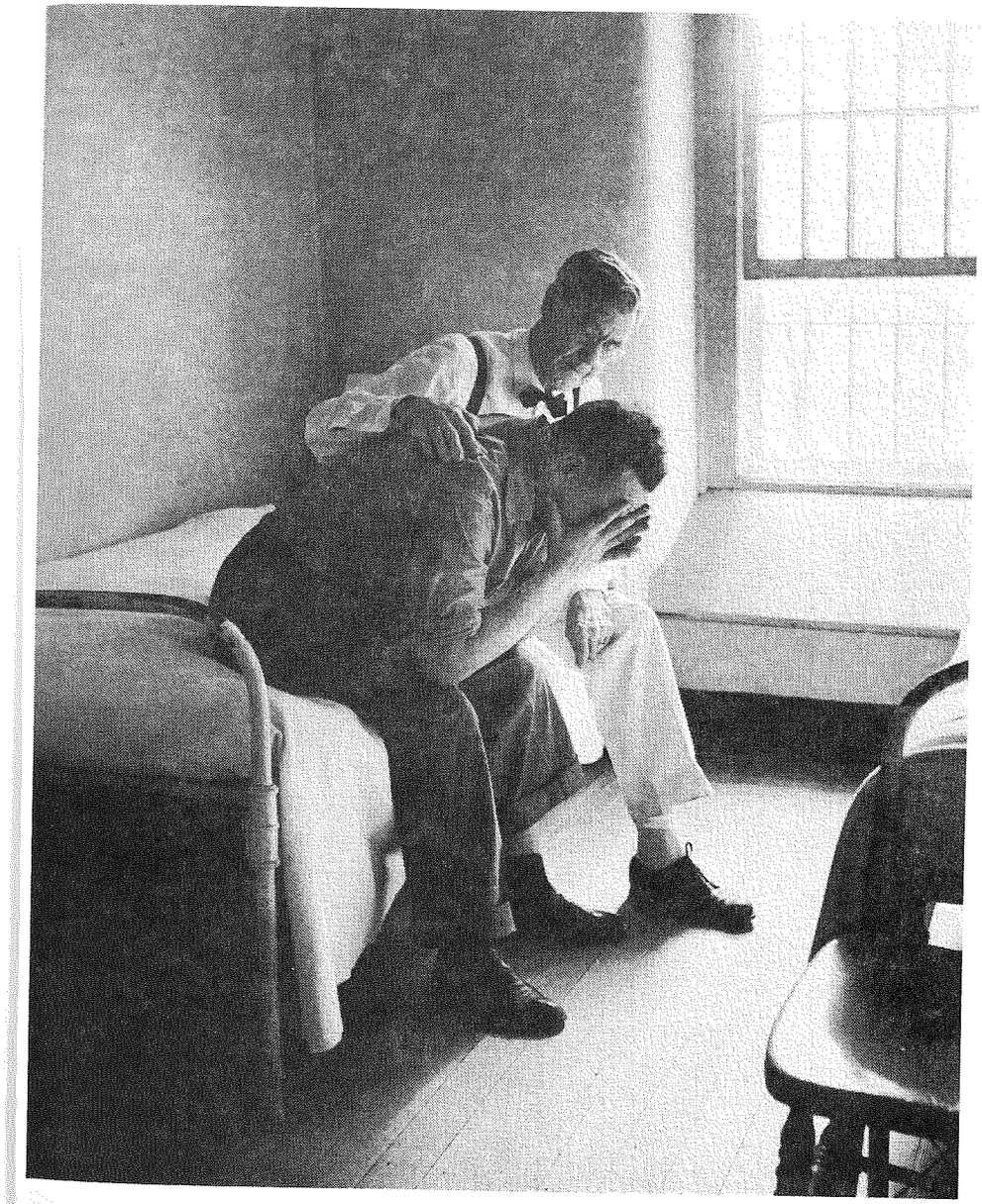
On the Avenue of Approach

2700 West Sixth Street
Topeka, Kansas (USA)

DEDICATED TO . . .

"Those Who Cared"

Dedication to others . . .



Our goal is to help . . .

Introduction

In 1875 thought was first given to providing care for the insane in Topeka, and on June 1, 1879, one hundred years ago, the first patient was admitted to the "Topeka Insane Asylum" and today, "Topeka State Hospital" is dedicated to providing the best possible treatment to the citizens of its 31-county catchment area in Northeast Kansas.

My reason for revealing the story of the "life" of this great institution is due in part to my own interest in the historical data of the hospital, but more importantly to tell others of the great progress being made in the field of mental health and the great stride forward by Topeka State Hospital in its first 100 years.

Barbara Hauschild

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In the Beginning . . .

The Legislature of 1875 appropriated $25,000 "for the purpose of building an asylum for the insane at some convenient and healthy spot within two (2) miles of the State Capitol Building in the City of Topeka." The following conditions were imposed: 1) that the plot be not less than 80 acres; 2) title to the land should be acquired without cost to the State. The City of Topeka and Shawnee County each contributed $6,000 and the present site was purchased.

The law provided that buildings should be constructed on the segregate or cottage system—one main central building with others only two stories

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high grouped around it. Each cottage was to accommodate 40 persons, or 300 persons in the aggregate, and not to cost more than $25,000 each.

In order that the State might reap all the benefits possible from the investment, this institution opened in 1879, when only two ward buildings with accommodations for 135 patients had been erected. The Administration Department was located in one end of one of the ward buildings, temporary partitions being put up to separate the offices from the patients' rooms. The kitchen and storerooms were inconveniently situated in the basement, and the laundry, boiler room and bakery were in temporary wooden buildings.

In the Spring of 1879, Dr. Barnard Douglass Eastman, then superintendent of the asylum at Worcester, Massachusetts, resigned to assume the superintendency of this new institution. On April 1, 1879, he at once actively engaged in necessary preparation for the opening of the institution. The first patient, E. A. H., of Nemaha County, Kansas, was admitted on June 1, 1879.

Only Eleven . . .

Only eleven men have led this institution as superintendent during the past 100 years—from 1879 until 1979.

Dr. Barnard Douglass Eastman

Dr. Eastman's superintendency of the institution was long and conspicuously successful, though on two occasions, for political reasons solely, his tenure of office was broken for short periods. Following each absence, he returned to the superintendency and did not finally sever his connection with the institution until June 30, 1897, when for a third time, he was relieved of his charge because of a change in the political administration of the State.

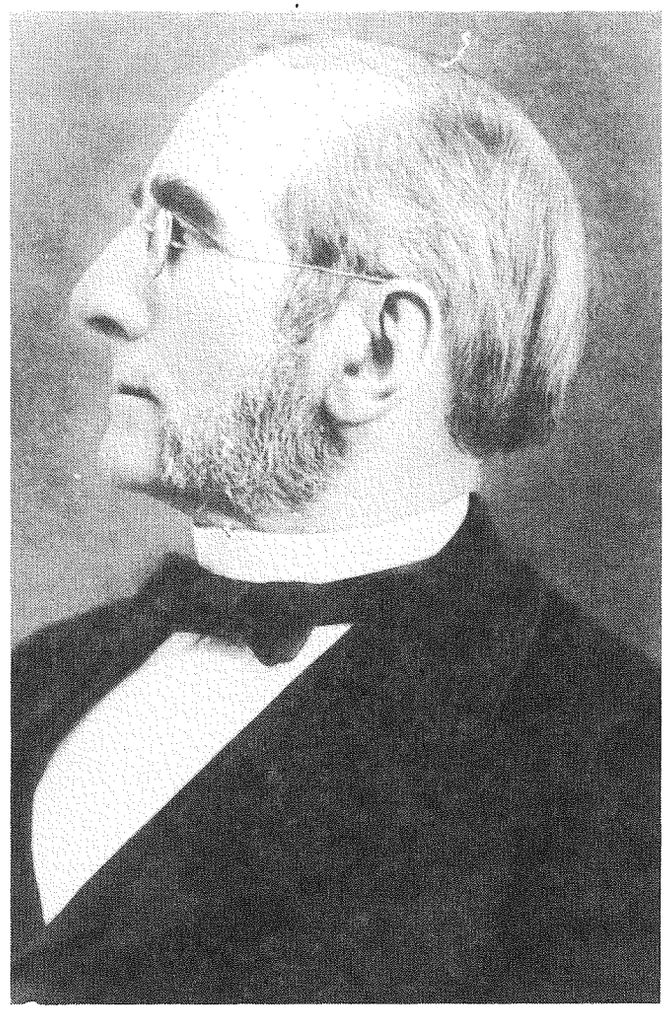
Thus for 15 years, during the development period of the institution, the State received the benefit of the services of this eminently efficient and honorable man. Dr. Eastman was first relieved from duty for the reasons above stated on July 1, 1883, and was absent until March, 1885, during which time Dr. Asa Pease Tenney was the medical superintendent.

Dr. Asa Pease Tenney

Dr. Eastman was again superseded July 1, 1893, when Dr. John H. McCasey was installed as his successor. Dr. McCasey remained in charge until February, 1895, at which time Dr. Eastman was for a third time returned to the superintendency and continued as such until June 30, 1897.

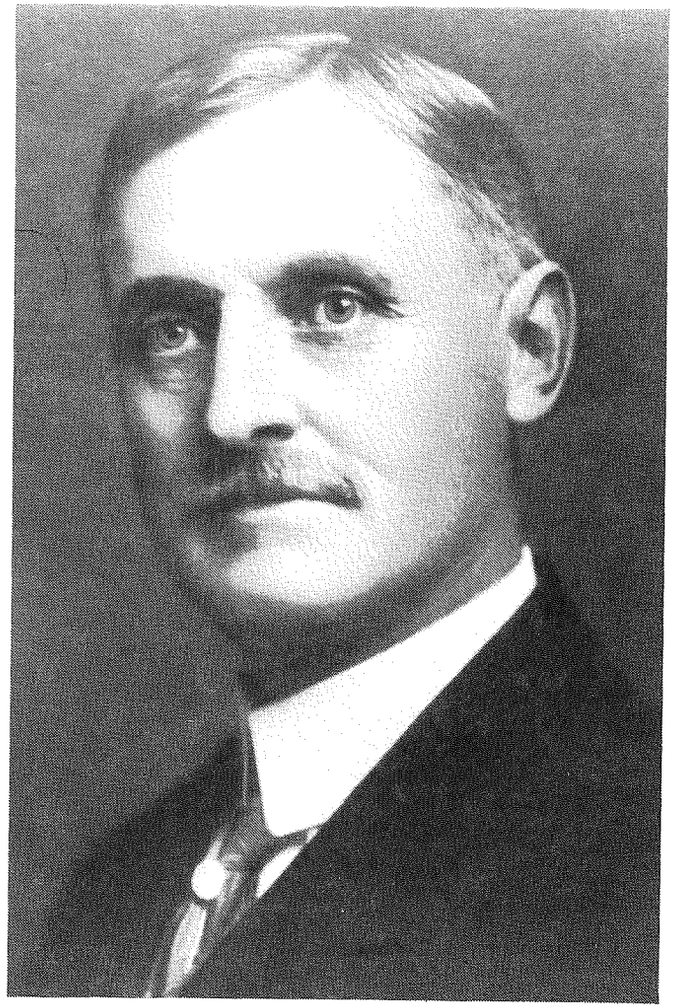
Dr. J. H. McCasey

Dr. Eastman was again superseded by Dr. Calvin H. Wetmore, who was superintendent until October 1, 1898. Following Dr. Wetmore's resignation, Dr. L. D. McKinley was acting superintendent until April 1, 1899.



Dr. Calvin H. Wetmore

At this point in time Dr. Thomas Coke Biddle was installed as superintendent and remained in this position until his death in February, 1918. Dr. John Hartson Cooper was named acting superintendent from February 16, 1918, until April 7, 1918.



Dr. Thomas Coke Biddle

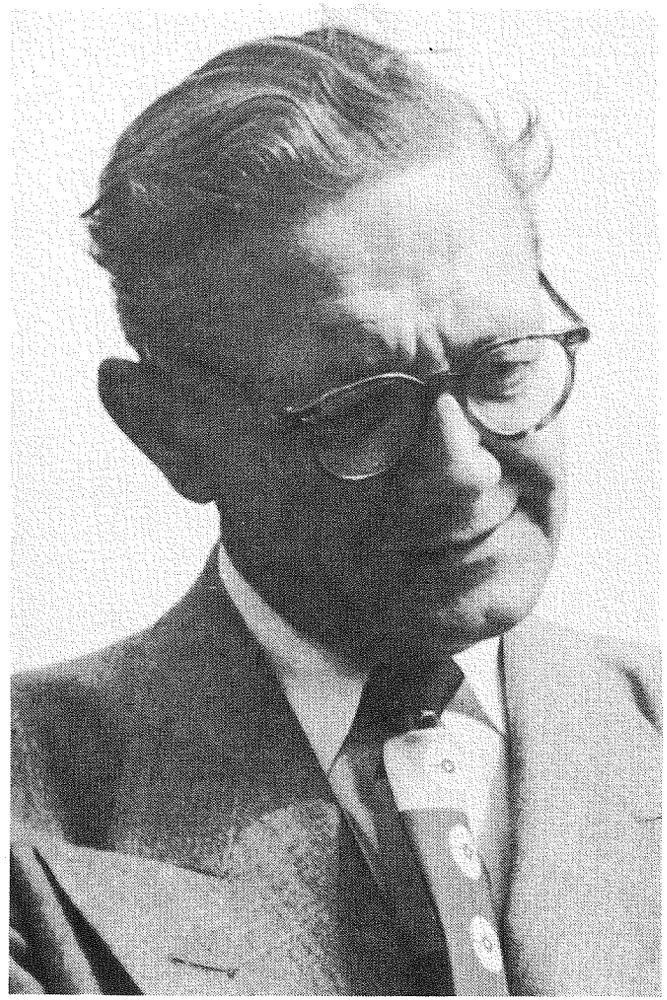
In April, 1918, Dr. Middleton Lee Perry was installed as the new superintendent, the position he held until April 30, 1948—30 years later.

Dr. Middleton Lee Perry

Dr. Paul Edward Davis was named superintendent in May, 1948, and stayed until September, 1948. Dr. William Francis Blair was made acting superintendent in September, 1948, staying for one year, until September, 1949.

Dr. Paul Davis

Dr. Leonard P. Ristine was named to the superintendency of Topeka State Hospital in September, 1949, and remained as such until 1951.



Dr. Leonard P. Ristine

Dr. John Martin Anderson then became superintendent in 1951, and remained until November, 1952, when Dr. Iverson Clark Case became acting superintendent. Dr. Case held that post until January 6, 1954.

Dr. John Martin Anderson

Dr. Alfred Paul Bay was named superintendent in 1954, and held the position until June 30, 1970, when Dr. George Zubowicz, then superintendent at the Osawatomie State Hospital, was named to succeed Dr. Bay on a temporary basis.

Dr. Alfred Paul Bay

Dr. Eberhard G. Burdzik, then Section Chief of the Eastman Section, was named to the superintendency of Topeka State Hospital in February, 1971, the position he still holds today.

Dr. Eberhard G. Burdzik

and enjoy . . . the comforts of home and contact with the outside world

AN OVERVIEW

How the Hospital Grew

BY ACT of the Legislature in 1901, the official name of the institution was changed from the "Topeka Insane Asylum" to the "Topeka State Hospital."

The *History of Topeka State Hospital* reveals many ups and downs in Kansas citizens' understanding and interest in treating the State's mentally ill.

Dr. Eastman told the Legislators what had been attempted to alleviate this situation. He said many patients had been discharged as improved to make room for more recent cases. "Some went away well enough to be in a measure useful. All were of a quiet and harmless character," he reassured the lawmakers. "Of those away on visiting leave, some may be discharged restored," he said. "They are at home to be near their friends and enjoy while they may, in an interval of comparative mental health, the comforts of home and contact with the outside world." Continued growth of the State and the "accumulation of old cases of insanity" contributed to the need for more beds, Dr. Eastman thought.

"Overcrowding was one of the most serious evils which could befall an asylum for the insane," he said. "Nothing else so surely impairs good order, the comfort of the patients, and curative treatment . . . when every bed is full, the arrival of a new patient in the night, perhaps, or a sudden outbreak of excitement in some cases necessitates the changing from bed to bed, room to room, and ward to ward, of sometimes eight to twelve patients."

He persuaded the Legislature to authorize construction of three wards which were completed in 1882. Other buildings were constructed as needed. The Old Eastman Building which was vacated in August, 1960, was constructed in 1885. Six new wards for women were occupied in 1887.

In 1888, Dr. Eastman wrote, "If the time has come when it is not practicable for the State to double its present holdings, it will be a sad commentary for all time upon the shortsighted policy which so often controls public affairs, and a belittlement to the success of the asylum."

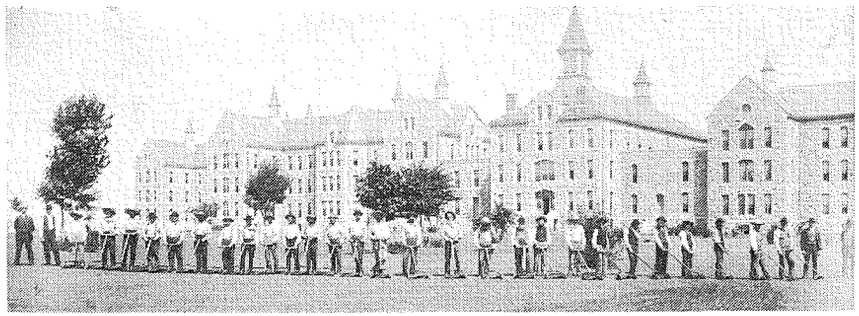
Dr. Eastman's insightful conception of his own and his employees' responsibility is as applicable today as it was at the time he opened the doors for the first patient. "It is a self-evident proposition that our eleemosynary institutions are the property of the people, are supported by the people and are for the benefit of the people. It is our bounden duty to administer the trusts imposed upon us faithfully, honestly, and fearlessly, and no one feels more keenly its magnitude than he who has the responsibility."

Dr. Eastman stated, "There must necessarily be one captain to a ship, one general to an army, and one head to an institution of this kind. The work is peculiar, and it calls for knowledge and experience in widely different directions. In the direct medical care of patients there is need for medical skill and experience, while their control and management calls for quick insight as to character and psychological conditions. In the selection, training, directing, and disciplining of employees, there is need alike for intuitive feeling and judicial decision. In the planning and erecting of buildings, there is a call for mechanical and sanitary knowledge. In general administration, there must be vigilance and economy. In dealing with the public, there should be courtesy and sympathy, as well as firmness and decision."

Though the superintendent was painfully aware of the scope of knowledge needed, actually little was known about treatment techniques. Dr. Eastman thought moral treatment was often the most useful.

"Removal from the worriment, the overwork, the unsanitary conditions, and the unsuitable food of many homes . . . firm control of the asylum, occupying body and mind in new employment, cheering, the drooping and melancholy and soothing the excited and irritable, are some of the elements of treatment of the greatest value, sometimes working rapid cures with but little medication," he wrote.

"To prevent mental illness," he said, "Kansas citizens must all unite in an earnest, practical, unintermitting campaign for physical, mental and



These patients and staff posed for a picture—before 1900. The building in the background being the Old Stone and Woodsview Buildings before the Center Building was built.

moral hygiene." Patients who were able, worked hard during the day. Some worked on construction of the new buildings. Others worked in the sewing room, about the grounds, or on the farm.

Vigorous work meant the patients needed hearty meals. A typical day's menu was the following: Breakfast—fish, eggs, ham or sausage, potatoes, oatmeal, bread and butter, coffee, syrup. Dinner—roast beef and brown gravy, mashed potatoes, baked beans, pickles or relish, bread, pie, tea. Supper—bread and butter, crackers, cheese, cake, tea.

"But," Dr. Eastman said, "it was impossible to please all the peculiar tastes of many of our people. They fancy their own home style of cooking furnishes a more appetizing meal than they get at the asylum."

Admission to the asylum was by the way of court, jury, jail and sheriff. Dr. Eastman, on *"The Rights of the Insane"* in 1896, argued eloquently for a newer, more humane, concept of mental illness. "Insanity," he wrote, "is a disease which should be diagnosticated and treated by medical men just as typhoid fever is . . . "

"Taking an insane person into court, forcing him to hear the testimony

. . . "Insanity," he wrote, "is a disease which should be diagnosticated and treated by medical men just as typhoid fever is . . ."

often coming from members of the patient's family . . . obliging him to listen to the necessary statements regarding his mental infirmity and a recapitulation of his delusions, may be likened to a case of severe gunshot wound brought into court. Six men from store, shop, or stable, successively push their bacteria-laden filthy fingers into the wound, the lawyers do the same thing, the sheriff takes his turn and the janitor has his opportunity and then the case is turned over to the surgeon,, who is expected to do an aseptic operation."

Succeeding superintendents concurred with Dr. Eastman and pressed for a change in the commitment laws. Actual impetus, though, for authorization of voluntary admissions came in 1919, from public sentiment about returning soldiers suffering from shell shock. Legislators changed the procedure to enable veterans to receive treatment in Kansas State Hospitals without enduring the indignity and public embarrassment of an insanity trial.

In 1903, women taking care of male insane was introduced and found that the decorum was improved and they added a markedly restraining influence on the ward. Force and intimidation were superseded by tact, kindliness and intelligence. From 1904 to 1928, Topeka State Hospital had a training school for nurses which had to be discontinued because of lack of funds.

It has been told that Dr. M. L. Perry, who was the superintendent here from 1918 until 1948, was a kindly man who knew each patient by name. For this thirty years, the hospital became a place where the management took almost as much pride in its agricultural pursuits as it did in its services to the mentally ill. At this time, the hospital had one of the finest dairy herds in the State. Many patients spent their waking hours in little huts of driftwood, tin and cardboard, on the edge of the hospital grounds, tending

Prize winning cattle, which were used to provide milk for the patients.

Little huts at the river's edge.

Many patients spent the day working in the gardens.

gardens. The patients gave little thought to leaving the hospital. Relatives of patients then in the hospital said they were assured by hospital administrators that their relative would be able to spend the rest of his/her life in the hospital—as though this were a privilege.

Preoccupied with the effects of the Second World War, the State Legislature, in 1944, drastically cut appropriations for salaries for hospital personnel. For the next two years the hospital was kept running by delaying discharging of some patients and putting them on the payroll at a limited salary. Civic leaders and newspapers brought the plight caused by this

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Then, in the aftermath of the war, came the revolution. . . .

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false economy to the attention of the general public. Enraged, the public demanded an investigation and then correction of the waste of normal human lives.

Then, in the aftermath of the war, came the revolution. In August of 1948, just after Dr. Paul Davis succeeded Dr. Perry as superintendent, three doctors at Topeka State Hospital resigned and the other supervisory employees threatened resignation as a protest to the level of patient care.

Governor Frank Carlson appointed a five-man committee headed by Dr. Franklin Murphy, Chancellor of the University of Kansas, to study the

state hospital's program. The press responded with numerous exposé articles deploring conditions at Topeka State Hospital and urging reform. *"A Study of Neglect"* was published.

This report on the conditions in the state mental hospitals proved, among other things, that the odds were two to one that a person entering a Kansas mental hospital would get better. The report was completed by October of that year. "We recognize in principle," Dr. Murphy said, "that Kansas cannot borrow from other states the trained psychiatrists, psychologists and technical personnel it needs because the shortage is universal. The committee is disposed to look with favor on a program that would be designed to tie the education of personnel to the service of patients in the hospital. We hope that whenever feasible, the teaching program can be brought into the hospital."

Members of his committee were Dr. Karl A. Menninger, Psychiatrist; Paul Wunsch, State Senator from Kingman; Paul Shanahan, State Representative from Salina and Dr. Haddon Peck, St. Francis, President-elect of the Kansas Medical Society.

The Legislature, acting on public demands and upon recommendations from the Governor's committee, doubled appropriations for the mental hospitals and directed the Topeka State Hospital to be made a training center for psychiatric personnel. The State later reorganized the Department of Social Welfare, providing for a three-man board which would be paid per diem and who would appoint a full-time executive and director of institutions. The superintendents of the State hospitals reported directly to the Director of Institutions. It also created a full-time advisory commission which would make recommendations to the board.

The book entitled, *"Ten Years of Progress, Topeka State Hospital, 1948-1958 . . . and Now Bricks"* by Dr. Alfred Paul Bay, superintendent, depicts the ten years following the revolution which may have been the most significant as far as the future character of the institution was concerned, because a pattern of treatment was created that would determine the success of the programs for many years to come.

The small professional staff organized an active treatment program, set up an educational program to train physicians in psychiatry, surveyed the building needs and took steps to meet community demands.

The hospital was overcrowded and deluged with requests for admission. Legal commitment papers could not be found for many patients, nor could some of the patients be accurately identified. Individuals who were adjudged "insane" by local probate courts were brought to the hospital without advance notice. Officials at the hospital in many instances had not questioned the individuals for psychiatric care, nor had they checked legality of the papers which accompanied them.

To attend to the immediate situation, the psychiatrists cared for the physical and psychiatric needs of the patients already in the hospital. The

business manager began to employ people to replace patient labor. The medical records clerk looked for the identity of some of the patients, clarified their legal status, and set up a medical records department.

Psychiatrists from the Menninger foundation volunteered some of their own time to help examine the patients, to determine who needed physical care and who was ready to leave the hospital.

Psychiatrists designed special wards for infirm patients. They ordered the long-used rocking chairs taken off other wards and prescribed general treatment programs for the patients. Desegregation of wards began.

Psychiatrists held daily meetings with their ward staff to discuss the

. . . The medical records clerk looked for the identity of some of the patients . . .

changes and problems of patient treatment. Attendants were asked to write behavior notes on each patient. Evidences of mistreatment of patients were investigated and corrected.

Many of the innovations frightened the attendants, who were accustomed to working under very different conditions. Upon the establishment of smoking rooms on most of the wards, attendants predicted, incorrectly, that the patients would start disastrous fires. The attendants became even more fearful about what might happen when the psychiatrists removed patients from the short extension halls where they had been kept chained and in the nude for months and sometimes for years.

In 1948, little or no attention was paid to physically ill patients. Medications were not available with which to fill the physicians' prescriptions. The hospital had no surgical equipment, no operating room. The laboratories and x-ray equipment functioned poorly. Dental care was non-existent and visual errors were left uncorrected. Physical therapy was not available and hydrotherapy was not used.

Progress in providing psychiatric treatment came slowly because so much had to be done. During these two years (1949 and 1950), the staff mainly had to be concerned with obtaining such items as clothing, hot water, soap, adequate food and other things for the physical welfare of the patients. It took until the end of 1950 to remove all the chains, handcuffs, camisoles, and straight jackets from the wards. Several patients remained in the hospital in 1958, who were victims of inhumane restrictions, one of them handicapped permanently because of being chained for too long in one position.

During 1948 and 1949, consultants from the Menninger Clinic Psychology Department assisted in organizing a department of psychology at Topeka State Hospital. In 1950, they cooperated in the training of psychology interns.

In 1948, only one psychologist worked at Topeka State Hospital, in 1949, two psychologists were on the staff, and in 1950, four staff psychologists and five psychology interns were working at the hospital. In 1948 and 1949, the functions of the psychologists were limited to conducting a small number of diagnostic psychological test evaluations. In 1950, the psychologists began planning research projects, and testing physicians applying for training in psychiatry. They started a comprehensive program to acquaint professional staff with the contributions psychologists might make in the treatment and training programs.

By 1951, the supervision and training of clinical psychology interns was concentrated at Topeka State Hospital.

Diagnostic testing, personnel selection and educational activities were expanded in 1952, and for the first time, staff psychologists were serving as consultants in other State institutions.

In 1953, the psychology internship training program was completely separated from the Menninger Clinic, and was financed by a grant from the U.S. Public Health Service. And, by 1954, all sections of the hospital were served by a staff psychologist.

Psychologists joined the staff psychiatrists in conducting interviewing seminars and supervising psychiatric residents in conducting psychotherapy. During this period the American Psychological Association approved the pre-doctoral psychological training program at Topeka State Hospital. Only seven state hospitals in the United States had received such approval.

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With the advent of psychiatric residents in 1950 and a gradual increase in the number of professional staff members, general medical care of patients improved and the death rate began to decline. Many patients who had recovered from their mental illnesses, but who previously had not been encouraged to leave the hospital took the opportunity to go home and work in the community.

On August 1, 1951, outpatient psychotherapy was made available to adults. During the first eleven months of this service, 246 adults came for treatment.

Another major innovation during this period was the beginning of the Children's Outpatient Clinic.

Prior to this biennium, no special provisions had been made for children, although a number of children under the age of eighteen years had always been in the hospital. In November, 1951, outpatient services of examination and treatment were first offered to any children in the State. At the same time, plans were made for the remodeling of a hospital building as an inpatient unit for children between the ages of twelve and eighteen years who needed hospital treatment. In October, 1952, C-Cottage was remodeled and opened for the treatment of 40 children between the ages of twelve and sixteen.

Regular Diagnostic and Appraisal Conferences were established, resulting in a closer coordination of all treatment acitivities. These years marked the beginning of group activities and of what was developed into milieu therapy (treatment by regulating the environment of the patient).

The use of restraints and seclusion and of locking up patients at night was prohibited, except upon written prescription by the psychiatrist.

Medical examinations revealed patients with active cases of tuberculosis intermingled with the rest of the patients. The superintendent designated a special ward for these patients.

The staff devised many ways to help patients leave the wards and visit in the community. They gave more patients the privilege of walking around the grounds unattended by an employee; of going downtown to shop, and for those patients ready to leave the hospital, of looking for a job. Families who had not visited the hospital in years were invited to ward parties to renew acquaintances with their patient-relatives.

On January 1, 1949, the first social worker was employed. This person worked alone since there were no established psychiatric teams. She began the first discharge plans for patients who were in remission and ready to leave the hospital. Then on August 1, 1949, the Social Service Department was established, and a staff of social workers was recruited. First order of business was plans for the discharge of patients waiting to return to their communities. Equally important was providing beds for persons who were waiting for admission, in many instances, coming from jail. The social workers began the never-ending task of finding community placements for the many patients who were ready to leave the hospital. To make the transition a little easier for the patients, the staff began to look for ways to acquaint long-term patients with recent changes in living conditions in the world outside. People from the community volunteered to help with this project and began what they at first called the "Bus Riders Club." Later on, the patients renamed it the "Beacon Club," and then they called it the

. . . acquaint long-term patients with recent changes in living conditions in the world outside.

"Golden Link Club" in 1951—the golden link between the hospital and the community. This club and several others with similar purposes fulfilled a valuable need at first because many of the patients had never seen the new home appliances, dial telephones, and the like. In 1951, the patients were acquainted with modern conveniences so the purpose of the clubs had been changed to that of helping patients ready for discharge to adapt to the social demands of modern living.

The position of personnel officer was established during 1950. Previously, personnel activities had been handled by the business office. All job

The turnover of aides was quite high during these years. Their starting salary was $75 per month, for a 13-hour working day. . . .

positions came under Kansas Civil Service regulations and applicants were required to pass competitive examinations.

The year 1952 marked completion of construction of the fire towers. Staff offices were moved off the wards and onto the towers. New modern office furniture was obtained.

The first group of five-year psychiatric residents arrived in 1952. Physicians in this program trained at Topeka State Hospital for three years and gave two years of service at other State institutions. The purpose of this program was to help provide psychiatrists to all Kansas state institutions. It had the immediate effect of providing temporary service to those short-staffed Kansas hospitals.

For the first time there was a physician for almost every ward. The number of nurses was increased to one for each two wards. By 1954, almost all the attendants had received in-service training and were fully qualified psychiatric aides.

During this time B-Cottage was converted into a central unit for insulin coma therapy. Several ward dining rooms were consolidated and redecorated. The long wooden dining tables were replaced with small, attractive formica-top and chrome-leg tables and chairs. new furniture, specially designed for Topeka State Hospital, was installed on most of the wards. The old beds were replaced and the remaining rockers discarded.

In 1951, the number of patients with tuberculosis stood at 85. Forty-two of the patients were housed in the TB Cottage. The other 43 were either inactive cases, or the activity had not been determined. Even on the TB Cottage the patients shared common drinking glasses.

The turnover of aides was quite high during these years. Their starting salary was $75 per month, for a 13-hour working day. They ate and slept on the wards with the patients in 1948.

The early 1950's came with each individual employee working with patients beginning to realize his/her importance in the total treatment program. At team meetings both administrative and treatment plans were discussed. Ideas and opinions expressed by each participant were considered on the basis of the merits of the ideas alone and not on the basis of the person's professional status.

Growth in knowledge and in feelings of security on the part of all team members enabled the chief psychiatrists to unlock permanently the doors to several wards.

Milieu therapy seemed to reach a high degree of development during this period. Activity group psychotherapy programs began on an experimental basis for alcoholics, adolescents, and chronic schizophrenics.

Research on the use of tranquilizing drugs began. This added the newest of the psychiatric tools to the hospital armamentarium at a minimal cost to the State. It provided impetus for a well-rounded program and stimulated research.

The hospital placed an increasing number of elderly patients who no longer needed psychiatric care in nursing homes. To help the nursing home operators become familiar with the special problems of these patients and with ways of treating them, the hospital staff began to hold week-long training sessions for the operators.

Under the leadership of a progressive superintendent and the Advisory Committee of the Shawnee County Medical society, general medical services were set up in 1949 and 1950, including a consultant service by medical and surgical specialists from the Topeka area.

A full-time registered electro-encephalogram technician was employed first during 1949 and 1950. Encephalogram (recording of brain waves) is essential for an accurate diagnosis of brain lesions.

By 1951–1952, a modern, air-conditioned surgical unit with up-to-date operating room and surgical equipment was set up on the third floor of the Biddle Hospital Building. A medical and surgical ward was opened for the treatment of the acutely, physically ill patients and for pre-and post-operative care of surgical patients. A physician-in-charge of this ward and an internist were added to the medical staff. A pathology and bacteriology laboratory was installed in the basement of the Education Building (formerly N-Cottage). A pathologist was employed. By 1951, all patients and employees were immunized against typhoid fever when North Topeka was flooded. Lung surgery was made available at Topeka State Hospital in 1952.

A chaplain was first employed by Topeka State Hospital in January, 1951, and Holy Week observances were held in the hospital chapel, and the first service of the sacrament of Holy communion was made to patient congregations. At this same time a bible was placed on each ward of the hospital. In June of this same year the first group of pastoral trainees (seven

in all) arrived for three months of clinical pastoral training. They lived in the "night engineers" quarters—second floor over A-Kitchen. Classes were established for Topeka area ministers. During the Winter and Spring of 1951, the interest aroused by the Grant Foundation sponsored sessions for parish clergy, led to requests for continued contacts with parish clergy and again sessions were held in Topeka and outlying points. This time it became apparent that there were advantages in meeting clerymen in their normal denominational and interdenominational gatherings. An outgrowth of this series of meetings was a request by clergy for specific contact with the hospital concerning admissions of persons from their congregation. A first draft of a form letter, indicating hospitalization of a parishioner was composed. Legal difficulties were skirted by including only facts of "public information." Subsequently this system of notice and consultation had, whenever appropriate, included the parish minister in the diagnostic conference, treatment program and therapeutic ministry to patients.

In the Spring of 1952, an invitation was received from a psychiatrist on Stone Section to initiate a "religious service" on the less ambulatory closed wards and services began on Wards D and G. The normal religious services had to be adapted to the patient group. Eventually, a useful form was devised and the results were published in the *Journal of Pastoral Care* as "Group Movement in the Ward Worship Service."

The following Winter (1953) a Bible Study Class was initiated with patients referred to it after careful review and prescription. Subsequently the class was opened for patients to come voluntarily. The class continued to attract some of the patients who were once called "religious fanatics." An evolving method which utilized rotational reading by members of the group

Clinical Pastoral Training which began in the Summer of 1951, had steadily grown, and was an accredited program. . . .

and group evaluation of religiously expressed eccentricities, had proven useful for rebuilding a socially acceptable contact with religion.

Clinical Pastoral Training which began in the Summer of 1951, had steadily grown, and was an accredited program. Since its establishment more than 100 clergymen or theological students had spent a three-month period in the hospital. Assigned to a section, these trainees made the routine initial pastoral visit on newly admitted patients, directed the referral letter to a home pastor when indicated, conducted ward worship services, conducted Bible Study Groups and hymn singing, participated in Diagnostic and Appraisal Conferences and provided (under supervision) appropriate pastoral care to patients. Although all the full-time chaplains in Kansas institutions had received training at Topeka State Hospital (or in a program

supervised by a Topeka State Hospital "graduate"), the larger group of trainees were parish clergy whose training was designed to aid them in understanding and helping mentally ill persons in the community.

Originally, training was offered for occasional three-month periods. Since 1953, it had proven valuable to extend it to 12-month internships in pastoral care. Admissions to the program were staggered throughout the year so that advanced trainees shared in the responsibility for supervision, thus qualifying themselves for similar positions elsewhere. In the midst of the general pressure of increasing hospital admissions and activity, this permanent trainee program had been the only method available for providing adequate religious services.

The seminar for residents in psychiatry and religion was offered annually each Fall as an elective course in the Menninger School of Psychiatry. For three years it had been taught by the Topeka State Hospital Chaplain and a Menninger Foundation Staff Psychologist. In 1955, the series was outlined to cover a three-year period.

The department of Allied Clinical Services was organized in 1954 to embrace all non-psychiatric medical services, except adjunctive therapies. The following services were a part of this department: medical and surgical ward, surgery and central supply, consultant service, employees' health center, laboratories, x-ray department, electroencephalography and electrocardiology, dental service, pharmacy, and physical therapy.

Case findings, case work-ups, treatment and rehabilitation of patients with tuberculosis were intensified. Chest x-rays were required for all new patients and of all persons before employment. Periodic skin tests for tuberculosis were instituted for all patients and employees. A public health service, including a control program for prevention of communicable diseases was started. Immunization against typhoid, paratyphoid, and tetanus, and vaccinations against smallpox for all employees was made compulsory.

In 1955, the pharmacy budget was increased to provide a supply of the tranquilizing drugs which research conducted at Topeka State Hospital proved to be effective for treatment of mental illness.

Also in 1955, an Employees' Health Center was established for emergency treatment of employees. And, by 1956, the requirement of a pre-employment physical examination was instituted. Nearly all laboratory tests and microscopic pathological examinations were being performed in the Topeka State Hospital laboratory by this time. Topeka State Hospital began performing all pre-employment physical examinations and laboratory tests for the newly opened Kansas Treatment Center for Children.

During 1957, all patients under 40 years of age were immunized against polio. Patients in other State institutions who needed chest or neuro-surgery were being transferred to Topeka State Hospital for this service.

Only two cases of questionable or active tuberculosis remained in the hospital It was no longer economical for Topeka State Hospital to care for the tubercular-mentally ill patients by 1958.

The X-Ray Unit was well equipped by 1958, and about 10,000 films were being taken and processed yearly.

A stock of useful drugs, including antibiotics, tranquilizers, and hormones were kept in the pharmacy by 1958. Any drug could be procured on special request of the physician. A Pharmacy Committee composed of three physicians and the pharmacist met regularly to plan for the pharmaceutical needs.

By 1958, forty-seven consulting physicians in all specialties rendered services to Topeka State Hospital patients and participated in the clinical-pathological conferences.

The physical condition of the medical and surgical ward was poor and in urgent need of reconstruction, and more space was needed to meet the demand for beds for acutely ill patients. Due to the increased demand for services the pathological laboratory, consultants office, electro-encephalography and electrocardiography rooms were overcrowded.

In 1958, a dental hygiene program which began in 1955 had to be omitted when budgetary restrictions reduced the number of hospital dentists to only one. Only emergency dental care could be provided. A second dentist and a dental hygienist were urgently needed. The Allied Clinical Services was losing personnel because salaries were below those offered at the other hospitals and laboratories in Topeka.

By fiscal years 1955 and 1956, a majority of the patients were undergoing changes in response to treatment. These were caused by the use of the tranquilizing drugs which had been introduced to the staff in 1954, for research purposes. The drugs proved to be effective and were prescribed for from 60 to 70 percent of the patients. The drugs enabled some patients who had not responded to treatment for many years to participate in meaningful activities.

Adjunctive Therapies and Nursing Service were taxed to the limit as activities were prescribed for more and more patients. Social Service time was overloaded as families renewed an interest and started planning for the discharge of their almost forgotten patient-relative.

Results obtained in treating more patients with the drugs almost eliminated use of restraint and seclusion. One hospital section of 355 beds reported that 15 patients were kept in seclusion for a total of 1,263 hours in July, 1954. This same section reported that use of seclusion averaged only 30 hours per month in 1956.

Caring for residents of a nursing home that burned gave the staff new ideas about ward treatment. A number of the elderly members of the home in Topeka were evacuated to Ward B on Stone Section. For almost a week

they were tenderly cared for by the patients who lived on that ward. This ward for several years had been a static, "do-nothing" ward. Staff members felt gratified to see their patients, who usually were so self-centered, actually enjoying giving something of themselves to other persons. This observation led to the permanent incorporation of this technique into the section's treatment program. Several patients from that ward regularly were assigned to assist the psychiatric aides on an infirm ward. Both groups of patients—the ones on assignment and the infirm patients benefitted from giving and receiving the extra attention.

Despite the rather careful preparation in the 1955-1956 biennium of the hospital personnel for unlocking some of the ward doors, the new arrangement began to create difficulties. Personnel deprived of the security of locked doors became anxious and viewed more critically the problems arising on these wards. Gradually, the personnel learned how to work out these problems and how to best use an open ward for treatment purposes.

It became apparent that one of the wards should be locked again. It was an infirmary and geriatric ward with a small number of psychiatric aides working on it. With the use of tranqulizing drugs and improvement of treatment techniques the general adjustment of patients on this ward improved. The patients became more active and aides were not available to accompany them off the ward. The patients began to get lost in their wanderings on the hospital grounds, so that the ward had to be locked again.

B-Cottage was remodeled into a second cottage for children to help meet the tremendous need for additional facilities for long-term treatment of severely emotionally disturbed and psychotic adolescents. Previous to expanding the children's unit, more and more adolescents had to be admitted to adult wards where they could not be treated as effectively.

All nine wards on an adult male section were reconstructed during 1955 and 1956 and new bathrooms were built on each ward.

During this same biennium, eleven psychiatric residents served on field assignments at five of the other State insitutions. Two residents worked at Boys Industrial School (Youth Center at Topeka), three residents served at Larned State Hospital, four residents served at Osawatomie State Hospital, one resident at Parsons State Hospital and Training Center, and one served at the Winfield State Hospital and Training Center.

To help provide competent administrators to head mental institutions, Topeka State Hospital, the Menninger Foundation and the Topeka Veterans Administration Hospital, cooperated in offering for the first time in 1956 a year's training in psychiatric hospital administration. Upon his graduation, one of the first two trainees accepted the superintendency of the Osawatomie State Hospital.

Fiscal years 1957 and 1958 showed the staff numbered 360 and the number of patients was 1,315.

New patients required proportionately more work than continued treatment patients. This period showed treatment for twenty-three percent more new admissions. Therefore, some administrative and treatment procedures had to be adjusted to compensate for the steadily increasing demands being made upon proportionately fewer personnel.

Less attention was given to individual patients, and more decisions were made on a group basis. In place of holding a customary pre-staff meeting for each individual new patient, the psychiatric teams met one hour each week to review histories of all patients admitted the week before.

The large increase in admissions and discharges placed the greatest stress on the Social Service staff, whose major work involved obtaining pre-admission information and making discharge plans. Often during 1957, only five or six empty beds were available for female patients. At such times the Admissions Committee approved hospitalization for only those women who were in dire need of immediate psychiatric care.

Employment of untrained persons to handle the technicalities in making nursing home placements alleviated the bed shortage somewhat. The social work aides speeded up discharge of many patients waiting to leave the hospital. And in 1958, from thirty to fifty beds were empty at all times on the adult sections.

Psychiatrists increased their efforts to direct treatment activites toward helping patients take more responsibility for themselves. They extended the trend started in the past of making more activites group oriented. Traditionally, personnel had thought new patients should be relieved of almost all responsibilities for the first two or three weeks of hospitalization. However, during this period staff members on one admission ward, expecting the patients to be able to return home within a few weeks or months, decided to give patients more responsibility, beginning with the first day of hospitalization. They established a patient government system and encouraged patients to participate in the management of their ward, to discuss their problems of daily living among themselves. The staff found this to be a step toward rehabilitating the patients right from the start of hospitalization.

A psychiatrist divided patients in one building into about eight groups of six to eight persons. Each group had its own leader who was responsible for carrying out the group activities. Daily the patients talked with the ward physician and nursing staff about problems that came up in the group activities. Sometimes the staff encouraged the group to help an individual patient work out his emotional problems that interferred with the functioning of the group. At other times, the staff would help an individual patient assist the group in overcoming its emotional difficulties.

Two groups of five elderly female patients met twice a week with two groups of five elderly male patients. Function of the group activities was to

help the old folks learn to socialize and to enjoy life. This ability often was limited severely by the process of senescence and had to be relearned. The group of both long-term and newly admitted oldsters conducted mutually beneficial projects.

The insulin coma therapy was replaced with tranquilizing drugs and therefore made a ward available which, in 1958, was converted to a "nursing home referral ward." Patients who were ready to make plans to leave the hospital and who would be going to nursing homes were transferred to this ward. The staff organized activities on the ward like those in a nursing

The end point of any psychiatric treatment program is helping the patient return to the community and renew relationships with his family, friends and industry. . . .

home so that they could help patients adjust to a nursing home environment before they left the hospital.

Experimental use of the "day hospital" was an extension of the "night hospital" program which had been in effect for several years for convalescent patients who worked days on a job in town while they planned to make the final move from the hospital. The staff developed the night hospital program for a few long-term patients who needed additional help with their readjustment back into the community.

The end point of any psychiatric treatment program is helping the patient return to the community and renew relationships with his family, friends and industry. To further assist patients in making a successful readjustment, it was felt that the hospital should have a counselor to help convalescing patients who were not quite ready to leave the hospital, to find part-time jobs in town. This would give the patients opportunity to earn spending money and test out their abilities for work before they were ready to tackle full-time work or remain outside the hospital all day.

Teen-age and young adult patients who became ill before they had learned work skills needed vocational training before they left the hospital, otherwise their chances for successful readjustments were less. This need grew more acute as the number of teen-age patients increased.

Now that more patients returned home each year, communities were looking to the hospital for help with local problems. As a result, psychiatrists and psychologists spent more than 400 hours per month in consultation away from Topeka State Hospital. Consultant services extended to local physicians and community agencies, nursing home operators, public health nurses, Riley County Mental Health Center, Fort Riley, Larned and Osawatomie State Hospitals, Winfield and Parsons State Hospitals

and Training Centers, Multiple Sclerosis Society, Kansas Rehabilitation Center for the Blind and the Kansas Treatment Center for Children. Other requests for consultant services could not be met because time of staff members was not available.

Despite numerous changes which made the treatment program more efficient, it seemed that more employees were still needed. For this reason the hospital requested, and received, state funds to conduct a research study on effectiveness of ward treatment for some of the most seriously ill patients. The purpose of the study called the Aid Saturation Program which began in July, 1958, was to determine the number of psychiatric aides needed to provide a maximum treatment program. Similar research was felt to be needed with each of the other professions which work with the mentally ill.

The Dietary Department provided a tremendous service to the patients. The following tells of the improvements from 1948 through 1958:

Prior to 1948: At the appointed time, usually well in advance of the meal hour, food was sent to the dining rooms, where it was dished out. By the time patients were allowed to eat their meal, the food had been left standing in uncovered serving bowls and unprotected for 20 minutes or more. When the patients came to the dining room they took their assigned places at the long crowded tables which served 20 or more persons. Should a patient want to sit beside a friend, the aide was instructed to take him back to his assigned chair.

Employees received better food than did the patients, though many of them ate in the patients' dining rooms, where special items of food on the employees' plates often caused resentment among the patients.

In the kitchens, each cook worked about 16 hours daily preparing meals for 150 to 300 patients. They cooked on wood and coal burning ranges

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In April 1949, the hospital employed a dietitian for the first time. . . .

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fired by patients. Hot ashes fell through holes in the bottom of the stoves and onto the floor.

In April, 1949, the hospital employed a dietitian for the first time. Three months later two more dietitians were employed. Employees and patients ate the same food.

In 1951, the cooking ranges were converted from coal and wood burning to gas. Some of the dining rooms were painted and window screens were installed to keep out flies. Many dining rooms needed venetian blinds and drapes for appearance and also to keep the sun out of the patients' eyes during meal time. Dining furniture was a hodge-podge of long wooden

tables and chairs painted many colors. Table cloths were used, but they were not changed as often as was needed.

Improvements in dietary service were made gradually. In 1953, electrically heated food carts were purchased for transporting hot food to the dining rooms. Dietary employees were assigned to serve measured portions of food. Previously patients served themselves and some took more than they could eat and very often there was not enough food left for the patients at the end of the line.

In 1954, dishwashing machines were installed in several dining rooms, to provide better sanitation.

Food was still being served from No. 10 tin cans, but early in 1955, serving utensils were purchased. The economy made possible the installation of a central vegetable preparation room. After all vegetables needed for the day's menus were prepared in this room, they were weighed and a certain amount apportioned for each patient. The kitchens were then assured of a sufficient supply of vegetables without an excess amount being left over.

In 1956, for the first time every patient was served with a complete set of matching dishes. Dietitians began training classes for dietary personnel. Remodeling of A-kitchen, which served 900 patients, was completed.

When new equipment for the bakery was installed in 1957, the bakers began baking enough bread to supply Boys' Industrial School (YCAT), KNI, as well as Topeka State Hospital. This resulted in a reduction in cost of bread to all three institutions.

At the end of the 1958 biennium, all cooked food was placed in covered containers in heated carts and delivered in an enclosed panel truck. Previously, uncovered food was transported in an open truck, where the food was open to dust, coal, soot, flies, etc. Though many improvements were made in dietary service within this ten-year time span, certain types of equipment were still needed to provide sanitary and efficient food service.

The Adult Outpatient Clinic had the privilege in its first ten years not only to begin its own existence, but also to participate actively in the birth of a second outpatient facility. Consultations between the Executive Secretary of the State Board of Health and the Director of the Division of Institutional Management, led to the pooling of resources of the two agencies to enable citizens of Manhattan to establish the Riley County Mental Health Center. The efforts since 1950 of interested citizens of Manhattan would make a separate story. The staff at Topeka State Hospital and the Manhattan group worked together constantly to activate a full-time mental health facility.

Services offered by personnel from Topeka State Hospital were primarily technical, since the Mahattan Center employed a full-time Executive Secretary. During the first month, negotiations between county officials, Topeka State Hospital, and other State officials, did much to establish quarters for

the new Center in the Riley City-County Hospital, to organize a record system for the Center, to purchase necessary office equipment, to agree upon charges for services to patients, and to adopt examination procedures for applicants for treatment. A psychiatric team from Topeka State Hospital made weekly trips to the Center to diagnose and treat patients. With the foundation of the Riley County Mental Health Center, the Adult Outpatient Clinic staff at Topeka State Hospital gained valuable experience in nurturing a new outpatient agency to functional maturity.

During the 10-year period (1948–1958) many innovative tasks were taken on by the Topeka State Hospital Volunteer Services Department.

1948—The recreation director initiated volunteer activities. In January, the first volunteers started a reading group which they called the "Thursday Afternoon Book Hour." This was also the first year that the townspeople brought Christmas gifts (most of the gifts were not new) for "forgotten patients."

1949—This was the year the two hospital volunteers organized SHARE—State Hospital Aides in Recreation and Entertainment. They set up a code of ethics for their work and asked the professional staff from the Winter Veterans Administration to present a 4-hour orientation program for them.

THE METEOR, a monthly news publication for volunteers and patients was first published. The Supervisor of volunteers initiated the STATESMAN, a monthly publication for employees. This was the year when, for the first time, volunteers escorted patients to the Kansas Free Fair. The Women's Division of the Chamber of Commerce and the Topeka *State Journal* were the first community organizations to sponsor a Christmas program for the patients.

The Council of Church Women set up a schedule to bring cookies to serve at parties for patients in 1949 and the Topeka Civic Service Club gave monthly cash contributions to the patients' Benefit Fund. And on Armistice Day and Christmas the American Legion and Auxiliary sent gifts to the veteran patients.

1950—A local square dance club initiated weekly square dances for the patients. Volunteers organized the Beacon Club, a club for long-term patients who needed help in becoming reacquainted with community life. The Interclub Council joined the Topeka *State Journal* and the Women's Division, Chamber of Commerce in organizing the community to send gifts to "forgotten patients." The council also sent refreshments for monthly patient dances. The Red Cross Canteen gave birthday parties and provided motor service to transport cakes to the hospital. The Council of Church Women also brought birthday cakes. The Beta Sigma Phi Sorority donated bleachers, wood, and sports equipment to the hospital. Specially selected volunteers began working with post lobotomy patients.

The year was 1951, and the Junior League opened the Quonteen, a "corner drugstore" for patients. Wives of the legislators made their first visit to the hospital. A regular six-hour orientation program was organized for new volunteers.

In 1952, a full-time Director of Volunteer Services was employed. Volunteers organized another club for patients to help them become acquainted with life in the community.

The year 1953 brought a number of donations, including several TV sets for the wards from various clubs and organizations, a kiln for C-Cottage was received from the Mud Hens.

The length of volunteer orientation programs was increased to 10 hours. The local chapter of the National Secretaries Association and Bell Tele-

In 1952, a full-time Director of Volunteer Services was employed. . . .

phone employees donated four big exhaust fans for the auditorium. The Volunteers received national recognition on the Mary M. McBride Radio Program.

It was also in 1953 when the Junior League turned the Quonteen management over to the hospital.

In 1954, the first Day Camp for the Adolescent Unit was held. A cement floor, the Richardson Slab, was installed outside for square dancing. Adolescent patients could swim at Forbes Air Base.

The year was 1955 and these were the memorable events:

1. The Salvation Army gave $600 for spending money for patients who had no money or resources.
2. The first policemen worked as volunteers.
3. A group of KU students worked as volunteers.
4. An article by the Director of Volunteer Services was published in the *Mental Hospitals* magazine.
5. An Assistant Director of Volunteer Services was employed.
6. The Fox Theatres in Topeka admitted patients and volunteers to afternoon shows without charge.

The instruction booklet for volunteers was printed in 1956.

During 1957, the following items of interest were noted:

1. Mental hospitals throughout the United States inquired about the organization of Volunteer Services at Topeka State Hospital.
2. Free admission for patients to attend local baseball games was offered. Free admission for patients to attend performances at the Starlight Theatre in Kansas City was begun.
3. Fishing at West Lake was set up for adolescent patients.

In 1958, a new police volunteer group was started, and the Santa Fe softball league played baseball with male patients not on the hospital team.

Toastmasters started the Gavel Club for male patients in 1958.

BUDGET PREPARATIONS—In 1948 budget requests were planned for two-year periods and submitted to the State Budget Division. Often hospital officials were asked to discuss the budget directly with the Legislature.

Budget procedures changed considerably in 1953, when the Division of Institutional Management and the Department of Administration were established. Expenditures were listed under activities and specified funds were allocated to each activity. Previously, only a sum of money was allocated for operating expenditures, without any activity designation. Since 1953, hospital budget requests have been reviewed first by the Division of Institutional Management and then the State Budget Division and the Governor.

Amounts of the salaries and wages expenditures had increased each year since 1948, to provide personnel required for the accelerated treatment and training programs. Expenditure in 1958 for the other operating expenses was only $4,731 more than that expended in 1953. Consequently the treatment program was hampered in many areas because of lack of sufficient furniture, equipment, medicines, supplies, etc.

In order to have a daily record of available monies, a machine accounting system was installed in 1958. The following year department chiefs received quarterly reports of their expenditures, to assist them in utilizing their funds to provide the best services.

Changes in purchasing procedure accompanied the changes in budget procedure. Prior to 1948, a "steward" purchased supplies directly from the vendor, except very large quantities or carload lots which were processed through the State business manager. When a hospital business manager was employed in 1949, he began making the purchases. Since 1953, the State Purchasing Department in the State Department of Administration had purchased items costing $25 or more.

The increasing tempo of hospital activities had created a corresponding increase in the variety and number of supplies needed. The warehouse which seemed adequate in size when it was constructed a few years ago could not contain all the supplies.

Styles of clothing purchased for indigent patients illustrated the changes in purchasing needs. Before 1948, the patients wore uniform, institutional-type garments which were made in the hospital sewing room. In 1958, the hospital was purchasing attractive garments in a variety of colors and materials, made in modern styles and individual sizes. The new clothing was more attractive and psychiatrists said it

had more therapeutic value. Though the cost of individual garments was about the same, expenditures for clothing had increased because the improved treatment program enabled more patients to participate in outside activities.

Perpetual and periodic inventories were established on all supplies. Before the Warehouse building was constructed, no control was possible with items stored in tunnel areas throughout the hospital.

The non-expendable property control system was inaugurated in 1954, and during its existence only four items had been lost. By 1958, employees had become "property conscious," and the Business Office had a detailed record of the condition and location of each piece of equipment.

When the system was inaugurated, about 10,000 non-expendable items were located on wards and in offices. A total of 15,676 non-expendable items were listed in 1958. Some federal surplus items of office and dietary equipment were still in use, but in poor condition and were to be replaced as soon as possible. Gradually old wooden office equipment was replaced with metal furniture, to eliminate fire hazards in the old buildings.

As soon as an item was not needed, it was disposed of in accordance with condemnation proceedings established by the Department of Administration. Sometimes broken wooden furniture which was unsuitable for another State agency would be utilized in the hospital adjunctive therapies program for patients.

COLLECTION PROCEDURES DURING 1948-1958—Statutory rates for hospital care from 1920 to 1951 were $5 per week, from 1951 to 1958, $12 per week and effective March 1, 1958, the rate was increased to $28 per week. Although billing rates had been existent on the statute books, Topeka State Hospital made no concerted effort to collect the charges prior to 1950. It was the custom to accept payment from those who volunteered to pay, and, in the early years of the decade, collections approximated $75,000 to $95,000 per annum.

In 1949, members of the Kansas Legislature visited the hospital. When they saw the inadequacies and realized that more money was needed, the Legislators suggested an active collection effort be made. During 1950 and 1951, the Business Office tried to make collections by sending statements to relatives who indicated a willingness to pay. But, soon after the Legislature increased the rate for hospital care in 1951, it became apparent that a more intensive effort to collect charges would have to be made by a separate office. As a result, the Fiscal Office was organized in 1952, to place the collection procedures on a basis in accord with the law and with good business practices.

Principle tasks assigned to the Fiscal Officer included keeping patients' accounts for hospital care; preparation of quarterly billing and annual demands, conducting correspondence regarding collections; interviewing patients and responsible relatives; and handling claim reports to insurance companies, the Veterans Administration and Social Security Administration. All legal matters connected with collections were referred to the Legal Division of the State Department of Social Welfare.

FARMING AND GROUNDS SERVICE DURING 1948-1958—At the beginning of this 10-year period about 240 acres was devoted to farming operations. Subsequently parts of the farm were purchased by the Menninger Foundation and the City of Topeka. Other parts were utilized for location of State agency buildings. Only 125 acres remained for farming operations.

In 1950, the hospital farm and gardens were cultivated with two horses and an old tractor. Another team of two horses hauled manure. In December, 1950, a tractor was purchased and one team of horses was sold. The remaining team was used to haul manure until one of the horses became ill in 1952. Patients hoed, harvested crops, and worked in the dairy. The milk from the hospital's herd of 175 registered Holstein cattle was not sterilized. It was simply bottled and sent to the kitchens for cooling.

In 1951 flood waters destroyed most of the feed and grain crops growing along the river bank and left the ground which had been used for seed and garden crops covered with sand and silt to a depth of from one to three feet. Garden crops developed poorly in the Spring of 1952 because of the flood damage.

1953, through the cooperation of the State Health Department saw the hospital improve the sanitary conditions in milk handling. Pasteurizers and new cooling equipment were installed.

During the 1954 biennium farming activities consisted of a very limited amount of grass seeding, removal of dead trees, cutting the grass, and gardening. In June, 1954, the grounds department was established in place of the farm department, and a qualified horticulturist was employed to take charge of caring for the lawn, shrubbery, trees, and greenhouse.

In September, 1954, the herd of approximately 175 registered Holstein cattle was auctioned off because experience proved that operation of the dairy was not compatible with other activities of a hospital specializing in intensive treatment. When the hospital was a custodial institution, many of the long-term patients came from rural areas and enjoyed working on the hospital farm.

Since organization of the Ground Service, several major projects were inaugurated, foremost of which was the emergency care of hundreds

of valuable trees which were either dead or dying and the establishment of a propagating bench and nursery. During 1954, more than 125 dead trees were removed from the grounds. Replacement stock which was disease and drought resistant was growing in the hospital nursery. The landscape architect had a five-year schedule for replacement of the dying trees.

Cut flowers were grown in the forty-two year old greenhouse and were distributed to the wards each week. A conservative estimate of the commercial value of the flowers grown each year was $7,000.

In 1968, Topeka State Hospital's purpose was four-fold; a treatment center offering inpatient, outpatient, day services, as well as research. It was a training hospital for professionals in the field of psychiatry, psychology, nursing, psychiatric aide nursing, activity therapy, social work, hospital chaplaincy and mental health information and was a center for education in mental health. And finally, it offered its services as a consultant to the communities which it served.

Pioneering a concept for treatment of the mentally ill, based on a method of hospital organization called "The Kansas Plan," the three State mental hospitals in Kansas, under the Division of Institutional

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. . . "The Kansas Plan," . . .

Management, Department of Social Welfare, captured the interest and imagination of mental hospital administrators throughout the country. Under the Kansas Plan, the Adult Division of Topeka State Hospital was organized into three semiautonomous treatment sections, (three little hospitals) each serving designated counties of the hospital district.

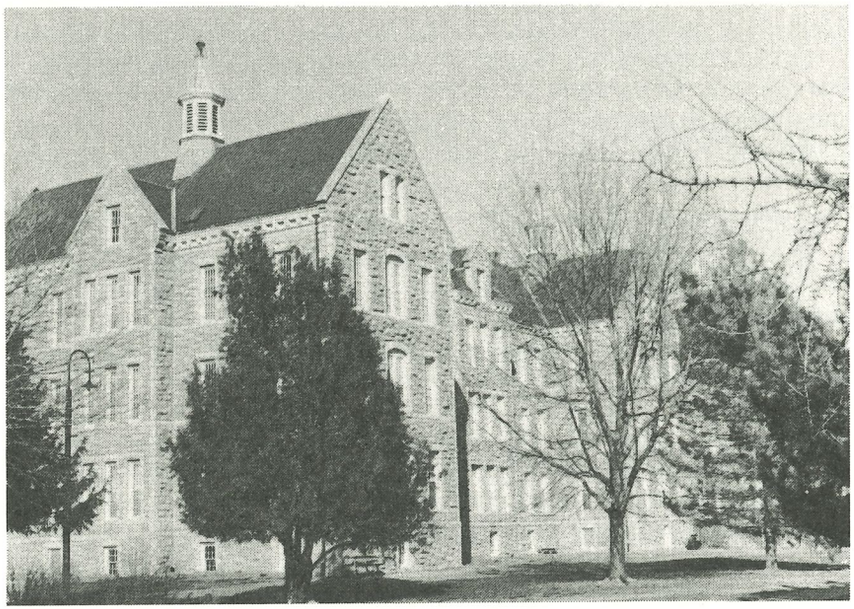
In a statement prepared in 1970, by then Superintendent, Dr. Alfred Paul Bay, he stated: ". . . that by 1950, an understanding Legislature had appropriated funds so that the State hospitals of Kansas could bring care to the people who desperately needed it." In 1970, he went on to say, "Topeka State Hospital will attempt to continue to bring fine service to its population. Just as Topeka State Hospital changed in the past, it is still changing today. We are treating more persons, younger persons and persons with different kinds of problems. Because the Kansas Legislature has invested in Topeka State Hospital, we feel they are entitled to know what our current programs and needs are. This information was gratefully dedicated to the Kansas Legislature in a 20th anniversary of the year when concerned Kansans turned a snake pit into an active treatment program. . . "

In order to give a brief resumé of the last 100 years, excerpts were taken from all the Biennial Reports to date:

. . . the last 100 years . . .

Years 1879-1880—The appropriations for the fiscal year ending June 30, 1880, aggregated $36,010, all of which was expended except $785.53. Dr. Eastman in this report made reference to the fact that an institution should be arranged to have at least seven or eight classifications for each sex rather than three for men and two for women. In the 13 months between June 1, 1879 and June 30, 1880, a total of 197 (123 men—74 women) were admitted. The number remaining in the hospital on June 30, 1880, was 121 (69 men—52 women). It was noted that of the 197 admitted during this period, only two were born in Kansas. Dr. Eastman spoke of the need for more buildings and more land to adequately serve the insane—which should be housed separately according to the cureably insane and those who could not recover. Forty-three persons were employed at the Asylum. The highest salary was that of the Superintendent which was $166.66 per month; the lowest paid was the Waiter Boy who received $10 per month.

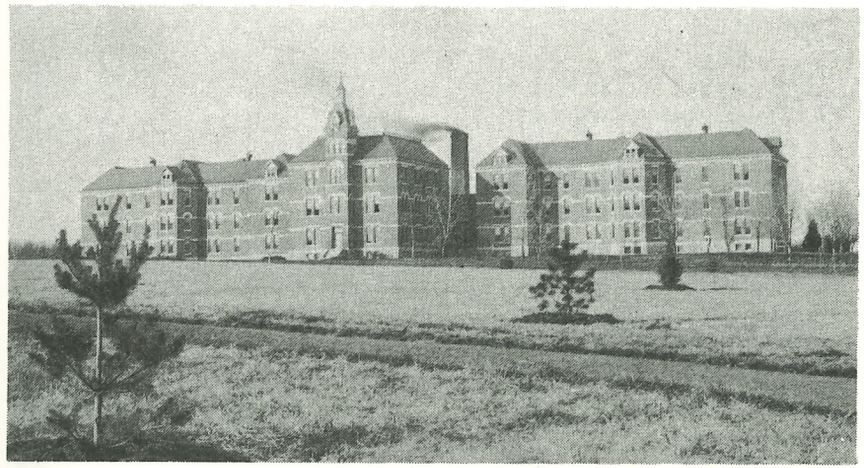
Years 1881-1882—A total of 145 patients remained in the Topeka Insane Asylum at the close of this biennial report. In this report, it was noted that additional land was purchased, and a new building built,



Old Stone

and the adding of a third story to the 2-story building occupied by women. It was noted that since the opening of the Asylum, Atchison, Douglas, Leavenworth and Shawnee counties had the most admissions. Forty-two persons were listed on the payroll at the end of this report period.

Years 1883-1884—By January, 1883, there were 227 patients. At the end of the biennial report on June 30, 1884, 492 cases were under treatment. Plans were adopted for the kitchen building, boiler house, laundry shop, connecting corridors, smoke stack, and for a detached building (Old Eastman) for chronic insane, for which appropriations had been made. The census of 1880 showed the population in Kansas of just under 1,000,000 and the number of insane was counted at 1,000. Based on these figures, more buildings were needed. Clergymen from the city came on Sundays for services which were attended by approximately one-third of the patients. Sixty-one persons cared for the patients during this report period. Dr. Asa Pease Tenney was the superintendent.



The Old Eastman (Detached Building) Building.

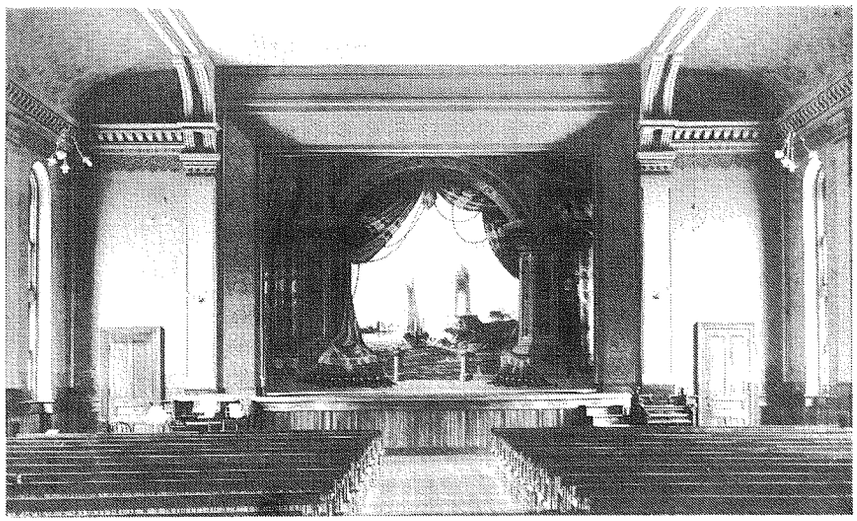
Years 1885-1886—At the end of this biennial period, there were 107 employees and 508 patients. The Edison Electric Incandescent System was put into operation during this time. It was free of objection as to odor, smoke and heat as opposed to machine gas; much safer also. The Topeka Insane Asylum had a capacity for about 700 patients. Oswatomie could provide for 500 for a total of 1,200. The number of inmates totaled 1,175 in both Asylums. Many were being turned away because of lack of space.

Years 1887-1888—This report told of the dedication of Asylum Hall (Auditorium) with a seating capacity of 600. An additional Asylum was felt to be needed, and the State divided into districts. The number of

patients remaining at the end of June, 1888, was 681. It was noted that improvements such as painting of wards, pictures hung, and in some areas dirt floors were replaced with cement. The Kansas State Board of Health made a visit and their report published in this biennial report stated: "For the Insane Asylum and its able Superintendent we have only words of commendation." During this period mention was made that the

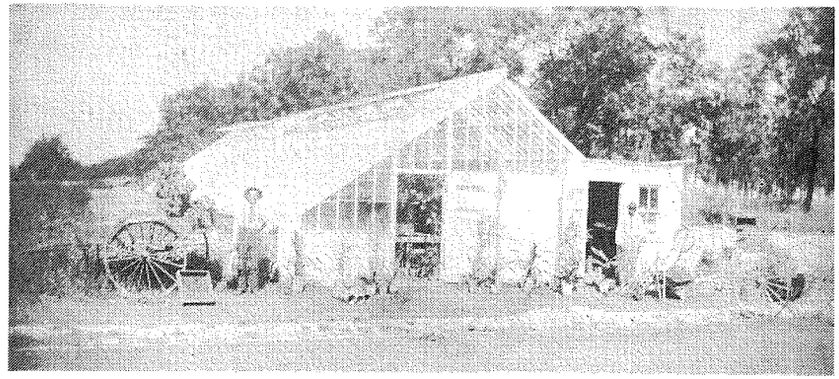
. . . "For the Insane Asylum and its able Superintendent we have only words of commendation."

exigencies and convenience of administration in an institution so large as this, with its numerous departments, some of them at considerable distance from the central office necessitated some modern mode of rapid intercommunication. This was met during this period by an Asylum telephone exchange, having stations at all the principle buildings and supplemented by speaking tubes between the different stories of the same buildings The avenue of approach long hoped for became a reality with the paving of Sixth Street from the city limits west to Martin's Hill. Of the patients admitted during this period, 54 were from Shawnee County followed by 38 from Leavenworth County. Four physicians (including the Superintendent) plus 126 other persons were employed at this Asylum. They were very appreciative of those persons who donated reading material and came to the Asylum to entertain the patients.

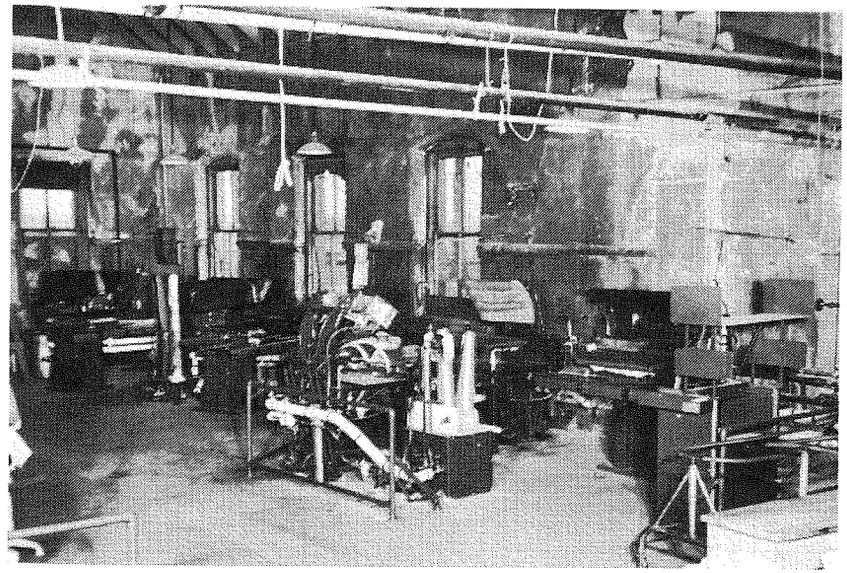


The Auditorium (Asylum Hall) many years was used for Church services and still remains today in the original part of the building, which is part of Center Building.

Years 1889-1890—All applications for admission had to be made to the Superintendent, according to Law. Topeka and Oswatomie were during this period at 758 patients at the Topeka Asylum and 519 at Osawatomie. This created a problem of putting two beds in a single room, thereby creating problems with quiet patients and the agitated patients. A greenhouse was constructed, the pump-house enlarged and a small building erected with a good cellar and a suitable refrigerator to properly take care of the meat.



The original Greenhouse erected in the late 1880's.



Many hours of toil were spent in this Laundry facility. Today a modern Laundry Building exists which provides a very needed service for other institutions as well as our own Topeka State Hospital.

Years 1891-1892—Dr. Eastman's plea for more space and more land continued. With regard to repairs and improvements he stated: "The folly of the penny-wise and pound-foolish principles of always letting building contracts to the "lowest-bidder" has been exemplified by the expensive repairs required on the roofing and plastering of the wards finished five years ago." The cry again for better water supply and fire protection was heard. The report lists 123 employees (including city clergymen) and 755 patients.

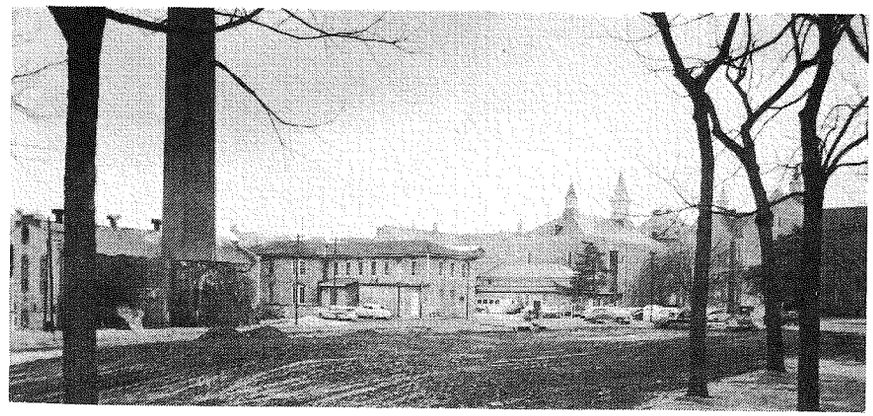
Years 1893-1894—At the end of this report, Dr. J. H. McCasey, Superintendent, reported 446 men and 317 women, for a total of 763 patients on the rolls. A shoe shop had been fitted up, and a patient easily did all the repairing for the institution. The making of rag carpet for the bedrooms and halls of the institution was started. The weekly use of fresh pork, for the entire institution, had been dispensed with, and chicken substituted. The use of butterine was dispensed with in March last, and good creamery butter used. Then in the laundry department, an ironer, for collars, cuffs, and shirts was purchased. The walnut grove along the river was cleared up and converted into an elegant park. The plea again was heard for a third Asylum erected in the West and more accommodations for women. Dr. McCasey acknowledged the attendants for their kind, courteous and considerate ways to those committed to their care, and also stated they had faithfully discharged all of the duties of their positions, which is worthy of the highest praise.

. . . 1,047 were under treatment and there were 127 employees. . . .

Years 1895-1896—Dr. B. D. Eastman, Superintendent, called for the urgent need of the center building and a ward building for women. For the first time in the history of the Asylum, it was necessary to go to the Legislature and ask for a deficiency appropriation, and $11,000 was granted. At the end of this report period, 1,047 were under treatment and there were 127 employees.

Years 1897-1898—On August 1, 1897, Dr. B. D. Eastman, having resigned his position as Superintendent of the Topeka Asylum was succeeded by Dr. C. H. Wetmore. During this period an additional building was completed for 120-125 patients, and more land was still requested. During the last biennial report and also the present report, there was talk of a number of consultants being brought in when needed, which was of great help. In this report Dr. Wetmore requested appropriations to meet the annual expenses of the next biennial report of $145,000—$100,000 for maintenance and repairs and $45,000 for salaries of officers and employees.

Years 1899-1900—T. C. Biddle, M. D., Superintendent, offered the following historical information with this closing report of the century: "The original act authorizing the erection of an insane asylum at Topeka was enacted in March, 1875. The act provided an appropriation of $25,000. Since that time the total appropriation for the completion of the Asylum and the purchase of additional land has amounted to $846,594. The general plan of the Topeka Asylum comprises a central building devoted to the administration department, in the rear of which are the domestic and mechanical departments, including, kitchen, laundry, bakery, boiler-house, and shops. On either side of the administration building are three ward buildings, each three stories high. These separate buildings are connected by one-story corridors; the structures on the west being used for the women's department (Old Stone) and those on the east for the men's department; (Old Woodsview) each building having a capacity for the accommodation of about 110 patients. The detached building consists of six wards, three on either side of the center or administration building. This building is used entirely for the accommodation of males and has a capacity for 289 beds. The institution as now equipped has a total capacity of 940 beds. With the increased room for patients that will be afforded by the completion of the administration building, now under process of construction, there will be accommodation for 970 patients. . . " The law provided that all applications for admission to either Asylum in the State shall be made to the Superintendent of the Topeka Asylum. On June 30, 1900, there were in the Osawatomie Asylum, 1,026 patients, and in the Topeka Asylum, 862, with a total of 328 insane who had been rejected, and since January 1, 1900, 21 more applications refused for a total of 249 insane persons being maintained outside of the two Asylums.



A rear-view picture of the hospital taken many years ago.

A view of the hospital from the front prior to the paving of Center Drive.

Years 1901-1902—Cases were still being turned away for lack of space. Salaries for all personnel were felt to be inadequate. According to Dr. Biddle, the most uncomplimentary provision for the care of the insane in our Kansas State hospitals was the inadequate night service. The assumption that three night-watches could give proper attention to 1,000 insane people was ridiculous and a burlesque on modern care of the insane.

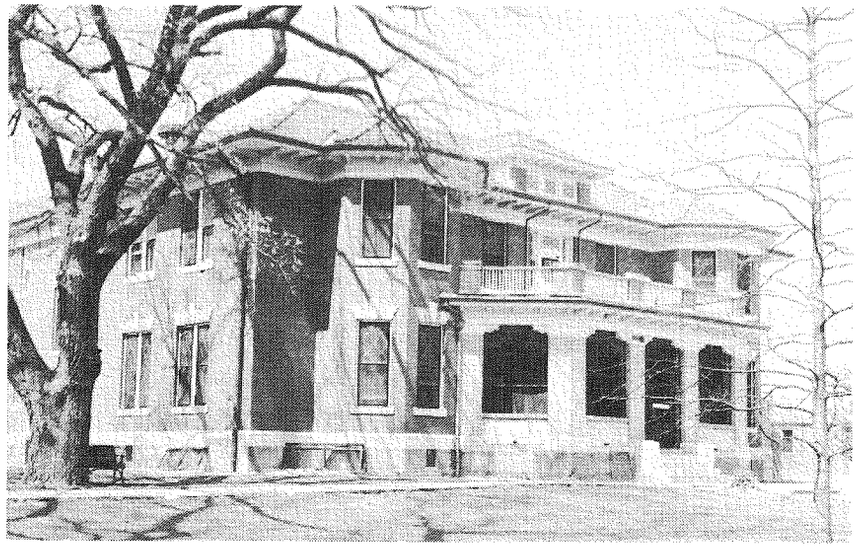
Years 1903-1904—In October, 1903, the Parsons Hospital for Epileptics opened and 50 male epileptics were transferred from Topeka State Hospital which was a most satisfactory arrangement. At the close of this report 996 patients remained in the hospital. Dr. Biddle mentioned that it was their purpose to eliminate the old Asylum method and inaugurate the modern hospital idea; to change the institution from an Asylum into a hospital in fact, as well as in name. The first class of nurses graduated on May 10, 1904. More training was felt to bring better care to the patients. Funds were appropriated ($45,000) and a new laundry was built. An additional 175 acres was purchased for a total of 350 acres. This included land situated directly in front of the hospital between the old institution site and the Sixth Street Road. A large valuable house on this land was suitably changed so that it could be utilized for the establishment therein of an open-door colony. The building would nicely accommodate 25-30 quiet male patients, where they proposed to have them engage extensively in poultry raising and other congenial pursuits. It was suggested that the steam service be changed at the pumping station to electrical power.

Years 1905-1906—Salaries were too low. Training was continuing. The employment of women in the care of the insane men was one of the more recent advances in hospital management. Laboratory tests were being taken and equipment purchased to enable doing surgery. The success with electrotherapy accentuated the importance of the agent in the treatment of mental diseases. Dr. Biddle requested that provisions be made for the segregating of tubercular patients. A small appropriation for the purpose of changing the barn at "The Pines" property into a patients' cottage was made. The request was once again made to the Legislature for additional facilities for the chronically insane women, of a cottage type. Items still being requested were: ice and cold storage facilities, adequate water supply, more land (even though some additional was purchased to bring the acreage total to 420), and fire escapes. The library consisted of approximately 276 volumes at the end of 1906. There were a total of 1,075 patients remaining in the hospital as of June 30, 1906.

Years 1907-1908—Admissions were increasing. The last Legislature was more generous than any other in providing for the needs of the hospital. Twenty-thousand dollars for a new pump, $10,000 for fire escapes and fire protection, contract was made for the construction of eight Kirker-Bender spiral escapes, $9,450 for 80 more acres of land, $70,000 for cottages for women with dining room and kitchen (Blanchard Construction Company of Topeka was awarded the contract), $50,000 for a custodial building for men. The contract was given to Henry Bennett

A valuable home (The Pines) on land purchased by the hospital, and later used for housing.

B-Cottage, once a cottage for women, was later converted to a unit for Adolescents, has now been razed.



C-Cottage, a cottage built to house women patients, was later used for Adolescents, has since been razed.

of Topeka and would house 150 male patients, and $12,000 for a pavilion for tubercular women was awarded to Blanchard Construction Company with a capacity for 14-20 patients. Sufficient equipment had now been added to the Laboratory to carry out various procedures which may be demanded of a complete clinical laboratory. It was determined that there was a need for a Reception Hospital and a request for $100,000 be appropriated for the building and equipment. A request was also made for an appropriation of $16,000 for a Tubercular Pavilion for

males. An additional $60,000 was requested for two custodial cottages for women. Enlarging of the Patients' Library continued. A Medical Library was instituted and 75 volumes of standard medical books were purchased. Religious services were continuing with clergymen from the city. At the end of this period, 1,100 patients remained, 736 men and 364 women.

. . . Working hours were long; an attendant worked from 5:30 A.M. until 8:00 or 9:00 P.M. with a half-day off every nine days—this, with an exacting duty that required tact, intelligence and trustworthiness, all for the sum of $270 to $390 per annum. . . .

Years 1909-1910—The after-care movement contemplated the organization of interested social workers. The bed capacity stood at 1,375 beds and the number of patients in the hospital at the June 30, 1910 date stood at 1,271. Voluntary admission was earnestly recommended to the Legislature. An Asylum for the criminal and vicious insane which was requested was not passed.

Years 1911-1912—Patients remaining hospitalized at the end of this biennial period totaled 1,384. On November 8, 1911, a patient attacked an attendant, D. F. Thompson, which resulted in his death. The Reception Hospital (Biddle Hospital) was completed. Still another cottage for women was appropriated for and Messrs. Carter and Young of Lawrence were awarded the contract. Working hours were long; an attendant worked from 5:30 A.M. until 8:00 or 9:00 P.M. with a half-day off every nine days—this, with an exacting duty that required tact, intelligence and

The Psychopathic (Reception) Hospital, later renamed T. C. Biddle Hospital, now houses other Social and Rehabilitation Services offices.

D-Cottage (Perry Cottage) now houses the Staff Library and Nursing Education and other Social and Rehabilitation Services offices. At one time was a unit for female patients.

trustworthiness, all for the sum of $270 to $390 per annum. Attendants and nurses were required to live among the patients which created many problems. Recommendations were made that the pay of the graduate nurse should be increased to at least $35 to $40 per month. A request was also made for two nurses' homes. Staff meetings were becoming an important feature of the medical work. A department for the care of the criminally and dangerously insane was established at the State Penitentiary at Lansing and some patients were transferred there. Several States including Kansas have enacted laws restricting the marriage of defectives. The hospital at Larned was being built.

Years 1913-1914—In mid-August, 1912, following a course of instructions to four pupil nurses in the technique and general principles of hydrotherapy, this form of treatment became a daily aid in the management and care of the patients. Sedative treatment was going far toward making the care and management of disturbed and restless patients more satisfactory. General surgery was by now quite common. Another cottage for 75 women was opened. This being D-Cottage now (Perry Cottage). One of the most attractive dairy barns in the West was completed here with a capacity for 120 cows with modern equipment. On June 30, 1914, 1,554 patients remained hospitalized.

Formerly the Dairy Barn, this building now houses the Engineering and Maintenance Department.

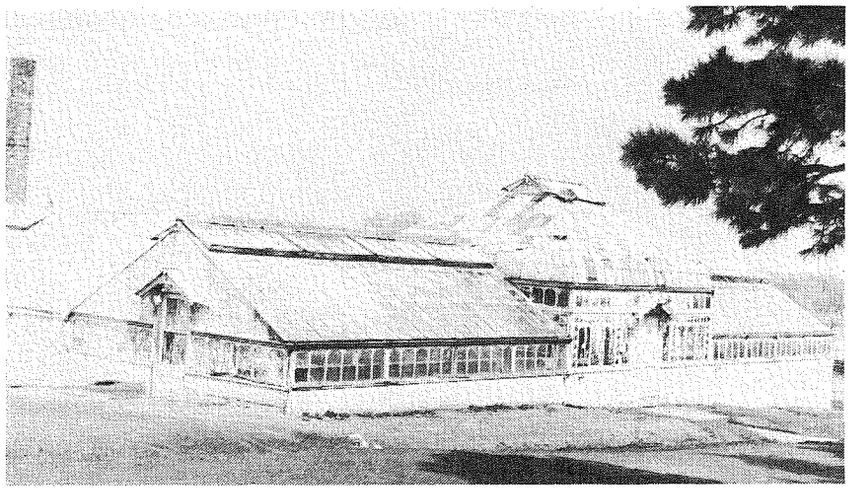
Years 1915-1916—Scheidel Western X-Ray Equipment was installed. At the end of this report period there were 1,567 patients. It was becoming increasingly hard to employ competent employees due partially to the low salary scale. The 8-hour day was established in Illinois, with satis-

. . . hard to employ competent employees due partially to the low salary scale. . . .

factory results. The Legislature of 1915 enacted a general civil service law. Housing for 40-50 employees was provided in an old domestic building. The water supply failed in February, 1915; this had been a problem for some time. With decrepit old ladies being accepted for admission, a special building, one story, with attached kitchen and dining room was requested. (The present Greenhouse was built during this period, although not so stated.)

Years 1917-1918—The institution as well as the state at large suffered a great loss in the death of Dr. T. C. Biddle, which occurred February 16, 1918 after a short illness. During the time of Dr. Biddle's superintendency, he had seen it develop from an old-time asylum into a modern and well-equipped hospital for the insane. All of the more

This building once served an an employees dormitory and now houses the Capital City School.



A more modern Greenhouse which has now been closed with the exception of some classes conducted by the School.

modern part of the institution was planned by him and constructed under his immediate supervision. Dr. Perry recommended that the new psychiatric hospital, to the designing and erection of which he gave a great deal of time, and which was recognized as one of the best arranged and

equipped buildings in the scientific care and treatment of the insane in the country be named the T. C. Biddle Hospital. Many building repairs were made throughout the hospital during these two years.

Years 1919-1920—These years found the hospital still in need of additional land. It was noted that the land values had advanced greatly in the immediate vicinity of the hospital in those years. During this period it was noted that the hospital had purchased land totaling $14,675.08. The hospital continued to have one of the finest Holstein herds in the state and an excellent dairy plant. The dairy produced

There were more cases of dementia praecox than any other form of insanity . . .

nearly 100,000 gallons of milk with a value of about $40,000 during this two year period. The chicken ranch produced 7,044 dozen eggs and poultry valued at $1,969.11 had been slaughtered.

Years 1921-1922—Good histories were being recorded for patients by the medical staff and 1,637 patients were in the hospital at the June 30, 1922, date. Staff meetings were being held regularly. A local dentist was coming to the hospital twice a week. There were more cases of dementia praecox than any other form of insanity with manic depressive insanity second. The Occupational Therapy Department was organized in March, 1921. "N" Cottage (built in 1907) was remodeled. Originally was a ward building, for Negro patients, and was later remodeled into an Education Building. Extending corridors from B and C Cottages to the dining room were completed.

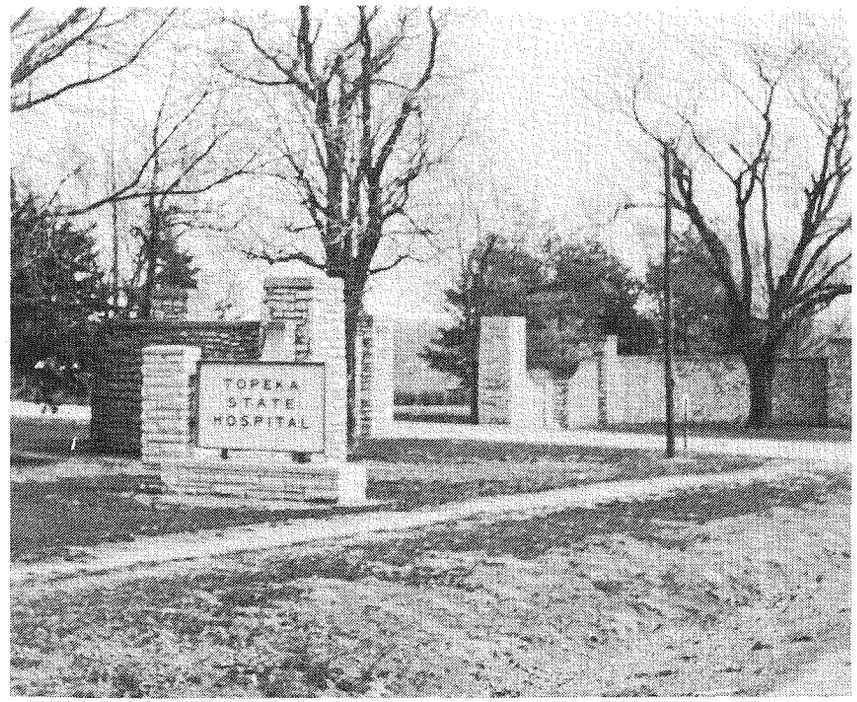
Years 1923-1924—The bed capacity was limited at 1,626 and 1,680 patients were hospitalized at the end of this report. The Topeka State Hospital had in past years established an enviable reputation among institutions of its kind because of the character of its medical work. Crowded conditions still existed and improvements were made in the way of pumps for the water supply. In fiscal year 1924, a total of $402,795.38 was expended for the operation of the hospital.

Years 1925-1926—The law passed in 1917—on sterilization of inmates in State institutions—was still in effect. Dental services were still being provided by a private dentist. The Training School for nurses was still operating even though the enrollment was very small. Overcrowding of patients was still in evidence. On May 7, 1924, a fire causing an estimated $18,500 damage occurred in the horsebarn haymow. Repairs in many buildings continued.

Years 1927-1928—There were 1,730 patients. Senior class medical students from the University of Kansas were coming to Topeka State Hospital and Osawatomie State Hospital for two week internships. The Training School for Nurses was suspended indefinitely. The Voluntary Commitment Law continued to be misunderstood by many. Overcrowding still existed. A herd of hogs was maintained in connection with other farm industries in order to use up the swill and garbage. The dairy herd continued to be one of the finest in the State. Several cattle were exhibited at the Kansas Free Fair each year where they were in competition with the best bred cattle in the country and they always succeeded in capturing a few ribbons. Some appropriations were made to repair Biddle Building and other maintenance repairs. Corridors were installed between buildings and dining rooms. A home for nurses was still desperately needed. The new tuberculosis cottage was built.

The Tuberculosis Cottage (north of Center Building) has now been razed.

F-Cottage (Feldman Cottage) later renamed for Paul E. Feldman, M. D., long-time Director of Research at this hospital, once housed male patients and was the last of the old buildings to be constructed in the 1930's, just prior to the highest population of patients in the history of the hospital. This building today houses the Child Development Center and the Children's Outpatient Department.



Gateway to the hospital—Sixth Street Entrance.

Years 1929-1930—Sterilization was continuing and misunderstanding of the Voluntary commitment Law was continuing. The hospital matron for many years died on December 28, 1929. Various repairs were made on buildings as were needed. The first building since 1913 was completed, that being F-Cottage (now Feldman Cottage). As of June 30, 1930, there were 1,684 patients.

Years 1931-1932—One thousand seven hundred and eighty-three patients remained in the hospital at the end of this period. Staff meetings were held regularly to study and diagnose the illnesses of the patients. A full-time dentist and pathologist were employed. An appropriation of $70,000 for nurses home was made.

Years 1933-1934—Sterilization operations totaled 426 to date. During this period there were 108 voluntary commitments. It was felt by Dr. Perry that the hospital was as large as it should be and no building appropriations were requested. In the Spring of 1934, some rather extensive landscaping along the Sixth Street border of the property was carried out by the Civil Works Administration and the State Highway Department. This included an imposing Stone Gateway at the entrance to the grounds. There were two salary cuts in this biennial period.

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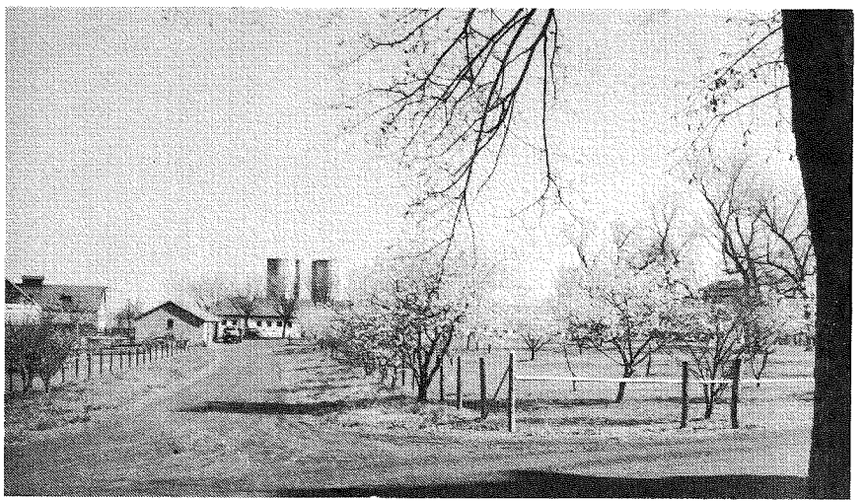
imposing Stone Gateway . . .

Years 1935-1936—There were 1,842 patients hospitalized at the end of this biennial period. Occupational Therapy was generally recognized as being of decided value in the treatment of some types of psy-



The fruit trees which provided many gallons of fruit yearly.

choses, particularly dementia praecox and mild depressions. The cannery constructed a few years before at a cost of $500 had paid for itself several times in the period in which it had been in operation. Many gallons of fruits and vegetables were canned each year. It was requested that the front drive leading from Sixth Street to the main entrance of the Adminis-

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. . . There were 1,903 patients . . .

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tration Building should be paved. During this period there were the following farm animals at Topeka State Hospital: 1,927 chickens, 120 turkens (not turkeys), 6 bulls, 17 calves, 92 cows, 37 heifers, 17 hogs, 6 horses, 4 mules, 55 pigs and 19 shoats.

Years 1937-1938—The patient population stood at 1,875. Two methods of producing shock were used, insulin and metrazol. Dr. A. C. Voth was employed as a resident psychologist. The garden suffered from the weather conditions, and arrangements for a type of irrigation system were made. Twenty-five acres of land was secured for this purpose. A fire destroyed the roof of the Pines.

Years 1939-1940—No building appropriations were requested as Dr. Perry continued to feel that the hospital was big enough. There were 1,903 patients at the end of this report period. Medical work was pro-

This former Nurses Home has now been renamed Smith-Wilson and houses another Social and Rehabilitation Services agency.

ceeding in an efficient manner. The psychologist was then carrying on personality studies. More attention to biochemical investigation was being given. The importance of oral hygiene was now being recognized. The first operation for sterilization was done at Topeka State Hospital. During this biennial period, 97 men and 40 women had this operation in this hospital without complications. Also during this period 84 patients were admitted voluntarily; 11 percent of the total admissions. A vacuum ash disposal system was installed. The $70,000 appropriation for the nurses home was approved.

Years 1941-1942—A decline in population (1,873) was seen because of not accepting harmless and chronic type patients and also improved financial conditions. This report talks for the first time of the "mentally

. . . "mentally ill" rather than "insane." . . .

ill" rather than "insane." A shortage of staff prevailed. Dr. Perry recommended a salary increase and requested $180,000 for this purpose.

Years 1943-1944—The patient population stood at 1,862. Repairs were made to the Engineer's Department. The farming progressed satisfactorily but for the first time, the dairy herd fell behind the garden in profit due to the high price of feed. In general, it was a stressful time—wartime.

Years 1945-1946—Many problems existed during these days; difficult to get supplies or competent help. Old timers and their loyalty prevailed. Overcrowding still existed (1,855 patients). Electric shock was being used. The psychologist, Dr. Albert Voth, conducted a rather extensive research project in personality testing of patients through the Autokinetic Phenomenon. A paper had been written on this matter and accepted by the American Journal of Psychiatry. A 10-year building plan was submitted. There were 232 employees on June 30, 1946.

Years 1947-1948—No biennial report was presented.

Years 1949-1950—Dr. Leonard P. Ristine was now superintendent and this was the first report since the hospital had been reorganized. It had been said about the hospital: "Inside, behind the locked doors and barred windows, 1,800 patients 'cared for' by three doctors (including the acting superintendent), one nurse, and 116 untrained, overworked, underpaid attendants. From ward to ward this reporter went past patients in straight jackets, patients bound to beds, through buildings long since condemned, and finally back to the outside. '. . . you sense the air of utter hopelessness, the penal atmosphere. . . .' he wrote. 'You cannot realize that there are fellow Kansans for whom you through your Legislature, have contracted to provide medical care. You know it is probably sinful and contrary to your knowledge of medical science, but you find

yourself thinking that most of these people would be better off dead'." In general, it can be reported that the intent of the 1949 Legislature to develop improved patient care and a training program was well on its way, and that up to July, 1950, progress toward that goal had been more rapid than was originally thought possible, due in great part to the efforts of Drs. Karl and Will Menninger. Patient examinations and classifications were made and patients were immunized. Sectional treatment teams were organized throughout the hospital. Medical and surgical care for the patients was made available in all specialties. A program of psychosurgery had been organized and the brain operation called lobotomy was being performed in a limited number of cases with apparent good success. A Department of Psychology was organized. The Social Service Department had been organized, as had the Activities Therapy Department. The Dietary Department procedures were re-organized under a competent dietitian, and a single food standard established. Laboratory services were being developed and additional equipment secured. Electroencephalography had been established. The Dental Department was also completely renovated, re-organized and re-equipped. The Nursing Department was established under which the whole nursing and Psychiatric aide (attendant) program was re-organized. In contrast to one nurse in 1949, 23 graduate nurses were on duty, most of them having had advanced training in psychiatry. It was anticipated that with the opening of the employees' building then under construction, that nurse-affiliate training in psychiatry could begin early in the next biennium. This would be an important step forward for both the State Hospital and for the undergraduate affiliate training of nurses in the schools of nursing of various Kansas general hospitals. Up to this time no psychiatric affiliate training had been available to those schools of nursing in Kansas. A complete procedure manual was written and placed on all of the ward services. Nursing made daily progress and special incident reports on patients. These reports became a part of the patients' clinical records. Complete nursing bedside notes were kept on all surgical and seriously ill patients. The Medical Records Department was completely re-organized. Under a competent Medical Records Administrator, these

. . . Drs. Karl and Will Menninger established the residency training program at Topeka State Hospital. . . .

records were re-arranged, brought up to date, and systematized. Receptionists' duties, switchboard, mimeographing and patient receiving procedures were organized under the Medical Records Administrator.

The Industrial Therapy Program was re-organized. A Personnel Department was established taking into account all facets of personnel work. The Business Offices were consolidated and improved accounting methods were introduced. Monthly departmental reports were established. Sanitary conditions were improved upon. A training chaplain was recruited to render religious services when needed depending on circumstances. The proposed training of psychiatric residents was in progress, beginning on January 1, 1950. Through an arrangement with

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. . . The number of patients still hospitalized at the end of this biennial period was 1,534.

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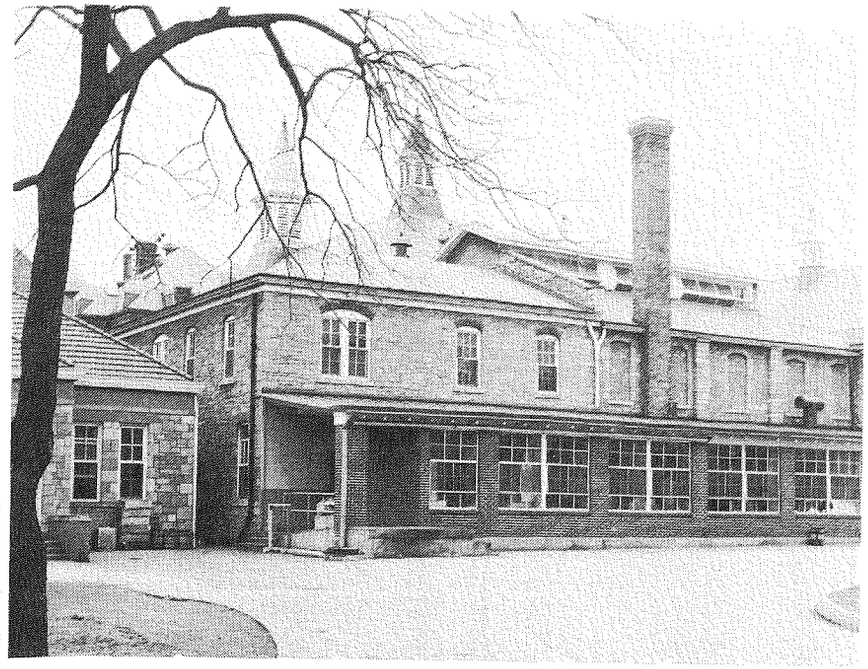
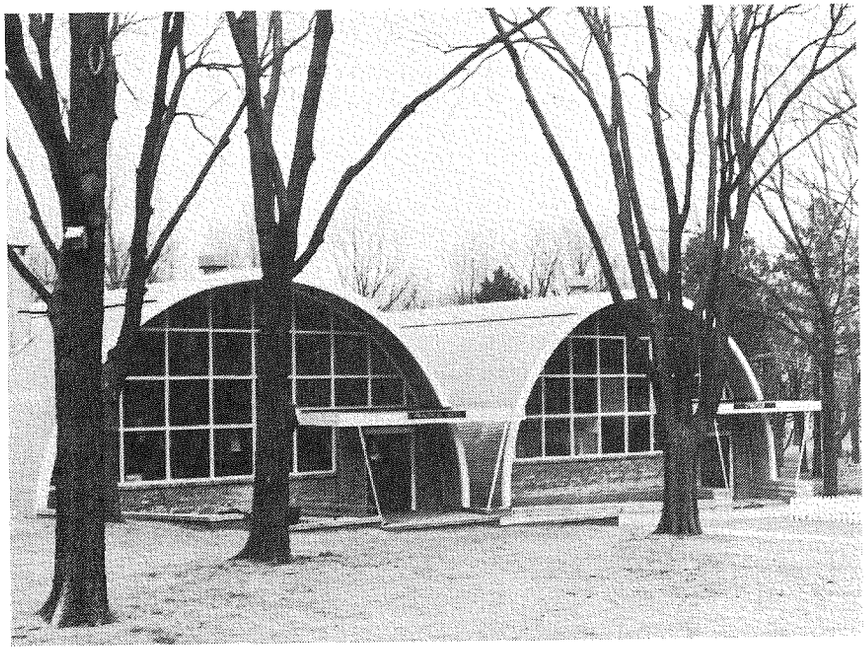
the Menninger Foundation and the Menninger School of Psychiatry, Drs. Karl and Will Menninger established the residency training program at Topeka State Hospital. Of the eleven organized in-service training programs established at Topeka State Hospital, the residency training program in psychiatry was perhaps the most fruitful program of all. The psychiatric aide training was also a great step forward. Physical changes included the so-called smoke towers for the main hospital building, the employees' building was under construction and completion was expected by September 1, 1951. The quonsets were under construction. The "A" Dining Room project was partially completed. The coal-handling equipment job was completed. Half of the main Stone Building had been rewired and relighted. A natural gas line was being laid. A new telephone system was installed. The Education Building (formerly "N" Cottage) was renovated to house the pathology laboratory, clinical laboratory and the morgue in the basement. Another part of the basement was made into the Activity Therapy Office and an Occupational Therapy Shop. (Picture of the ship was an example of scenery made by patients in the Occupational Therapy Shop.) The main floor of this building contained a small but growing Medical Library, Psychology Offices, interviewing Rooms, a Psychology Experimental Laboratory Room. The dormitories of the upper floor were converted into classrooms for the training schools. During 1949, most all of the old central administrative section was re-arranged and re-decorated. It was determined that the doctors, except for the Superintendent and the Clinical Director should have their offices on the wards rather than in a central administrative location. A number of Activity (Occupational Therapy) Shops were set up in old space formerly unused. A beauty shop was also provided. Kitchens were improved and new equipment installed. Office equipment (typewriters, files, etc.) was purchased, as well as bedside tables, storage cabinets for Occupational Therapy and more modern equipment for the Pharmacy. The number of patients still hospitalized at the end of this biennial period was 1,534.

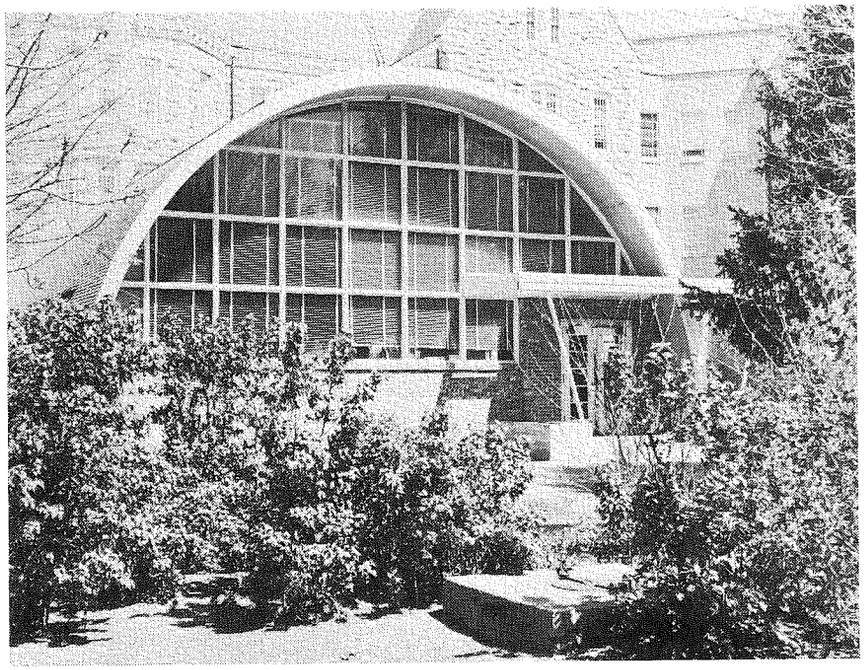


A rear view of Center Building with the old smoke-stack-long since removed.

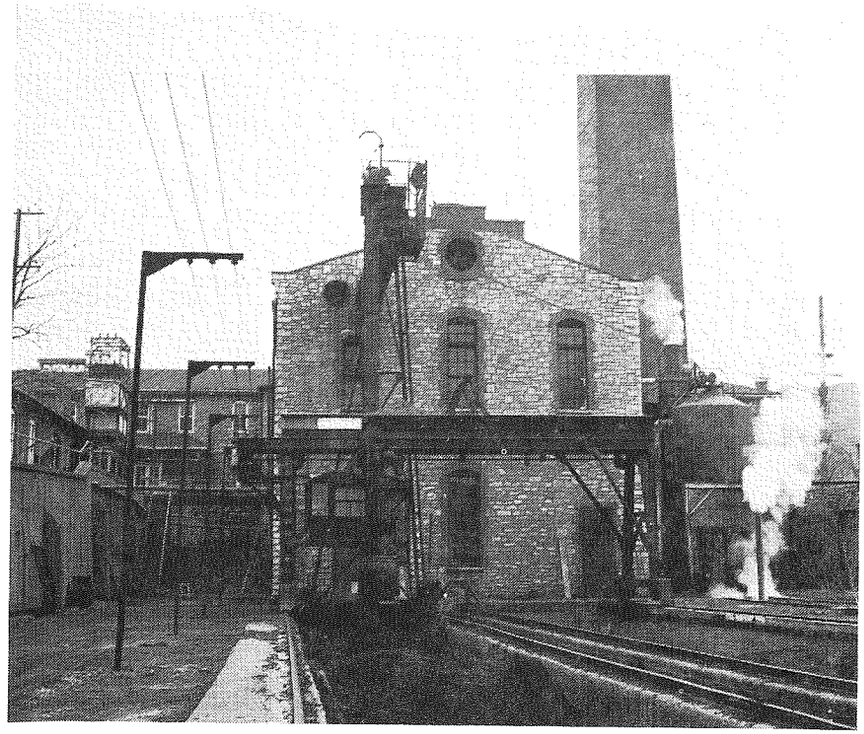
Another employees dormitory which has been converted to another Social and Rehabilitation Services agency.



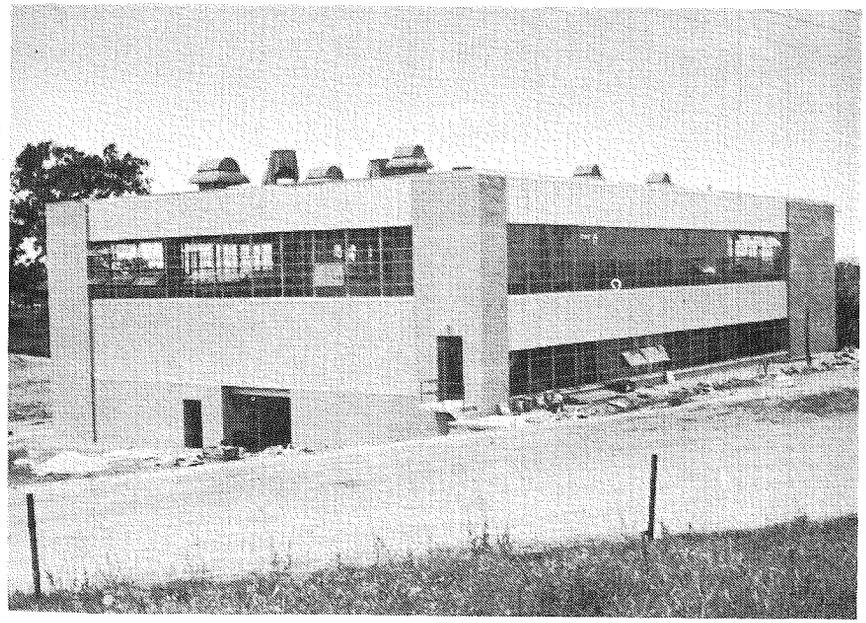
These quonsets today house the Gymnasium and a storage facility.

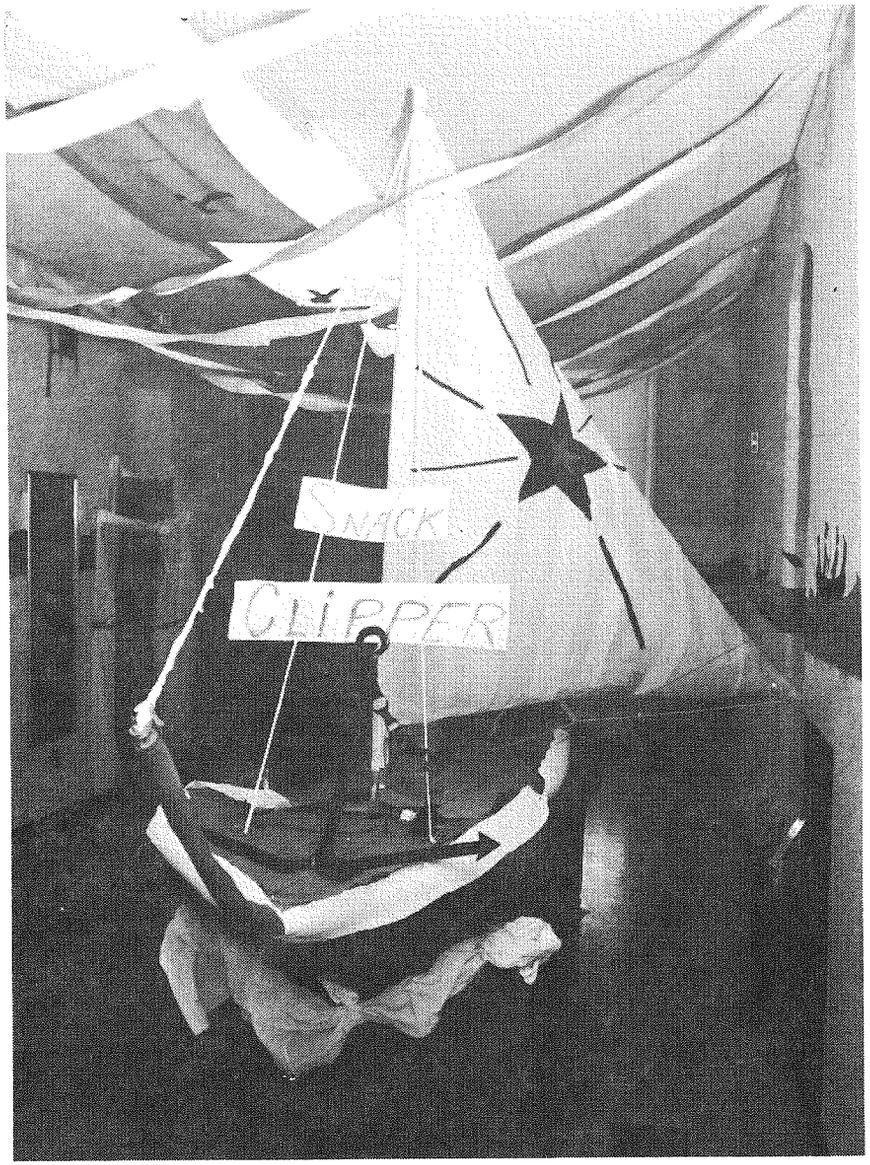


This quonset was long used as a patient-staff coffee shop. Today houses the Therapeutic Work Center.



The old Power Plant located behind Center Building has now been destroyed and the new Power Plant built to take its place.

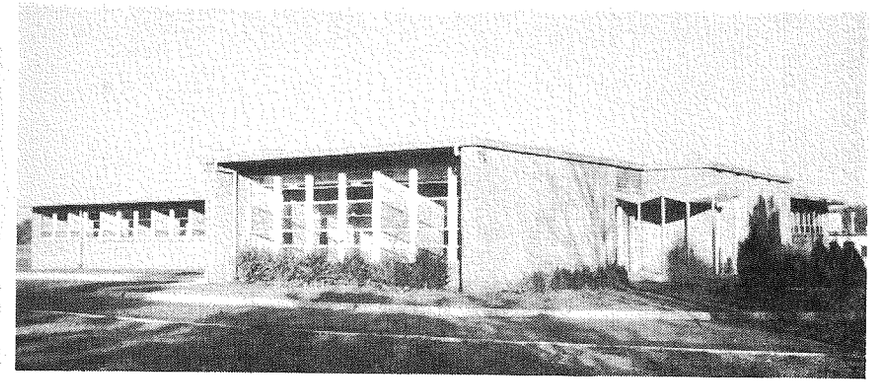




A Patient Project.

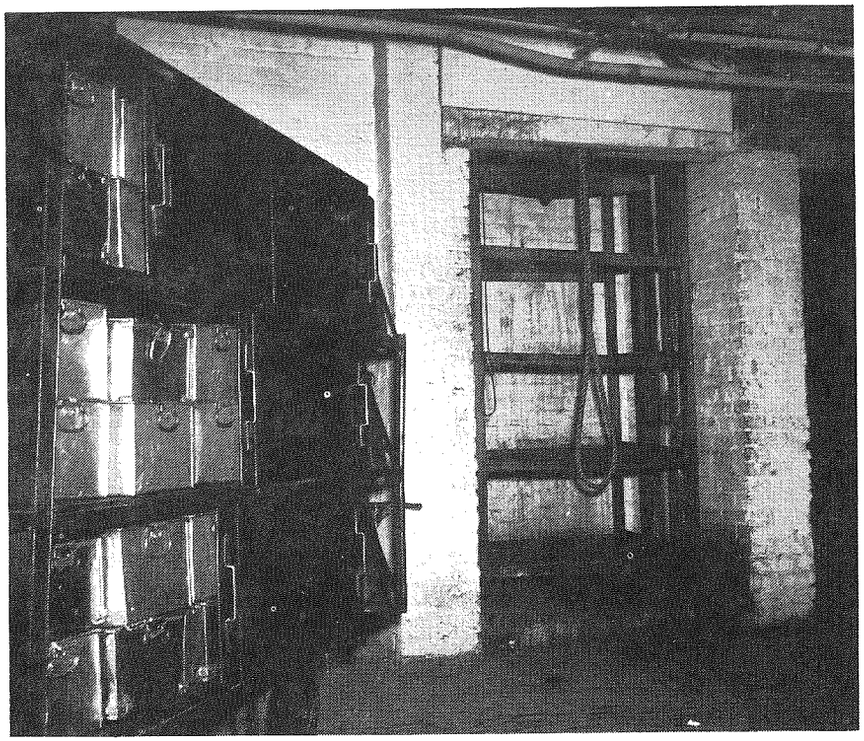
Years 1951-1952—Dr. John M. Anderson was named the new superintendent, and the hospital now operated under the State Department of Social Welfare. The hospital census continued to show a downward trend, despite a sharp increase in admissions. In contrast to the organization of most mental hospitals where there was usually an admissions service, an acute treatment service, a chronic service, etc., this hospital

was organized into four sections each of which was staffed with a complete psychiatric tream made up of psychiatrists, psychologists, social workers, nurses, aides, and adjunctive therapists. Patients were admitted to and discharged from each of these sections. They usually remained on a given section for the entire period of their hospitalization; thus the same group of staff personnel worked with the patient throughout the course of his/her illness. Inasmuch as there was an active treatment program on each section, there was considerably less opportunity for "back" wards to develop and greater assurance was provided that all patients would get as much treatment as possible. This unique plan, the idea of Dr. Karl A. Menninger, prevented the shift of patients from section to section. In addition to the various events of the time, two major steps were taken which would have far-reaching consequences for the future development of Topeka State Hospital. During the biennium the hospital was inspected by the council of Medical Education of the American Medical Association for formal accreditation for psychiatric residency training. The hospital was also inspected by a representative of the Central Inspection Board of the American Psychiatric Association. A department of Child Psychiatry was organized for children under the age of 18. The Adult Outpatient Department was organized on August 1, 1951. The Adult Outpatient Building shown below was built in 1960.



The Volunteer Services continued to expand as did all other departments The Farm Department continued to provide as in the past, however, the 1951 Flood destroyed most of the feed and grain crops as well as the garden products. It was recommended that a new Laundry Building be provided. Closer liaison with the Topeka Fire Department was established with the hospital. The Housekeeping Department consisted of a matron, two housekeepers, four janitors, nine institutional workers and one seamstress. Only very limited quarters for employees were available. The dining rooms and apartments on the second and third floors of the Administration Building had been converted to offices. A new attendants'

home which provided sixty-seven modern rooms for housing employees was opened in June, 1952. The picture below shows a dumb-waiter used in the Administration Building for transporting food to the upper floor apartments.



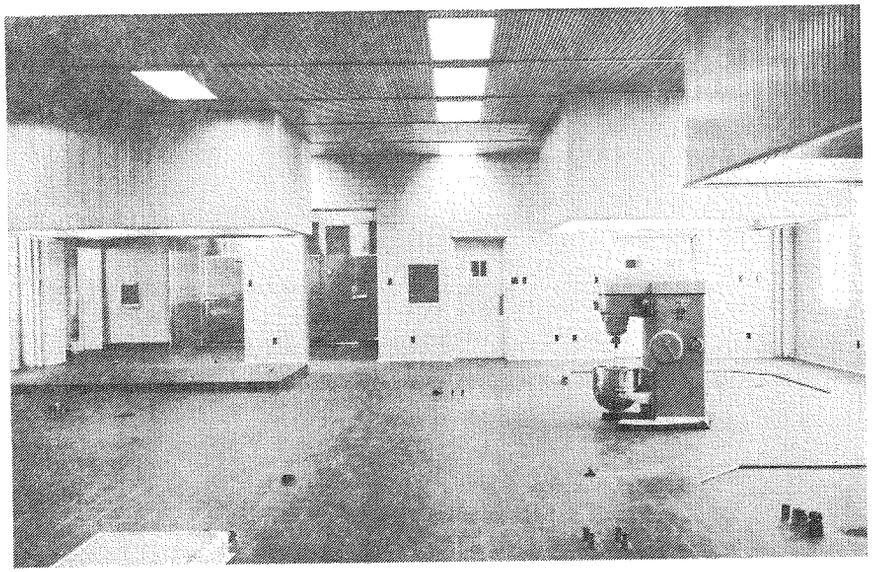
There were two very small cottages for the superintendent and the clinical director, four very old and deteriorated cottages in the rear of the hospital grounds, an apartment in the dairy barn, parts of the second and third floors of Eastman (Detached Building) which were inadequate, the fourth floor of the Administration Building, the Employees' Dormitory and the Nurses' Home, in addition to the new attendants' home. At the end of this biennial period there were 682 employees and approximately 1,400 patients.

Years 1953-1954—In the Thirty-Ninth Biennial Report of Topeka State Hospital for the period ending June 30, 1954, it was stated that Topeka State Hospital, situated in the Northwest part of the City of Topeka, had, since 1879, served the mentally ill from the Northeast portion of the State of Kansas. In general, it consisted of three large buildings of the Kirkbride plan in which the majority of its 1,400 patients were housed. The hospital had its own power plant, utilities, farm, laundry and sewage disposal plant. The area served by the hospital

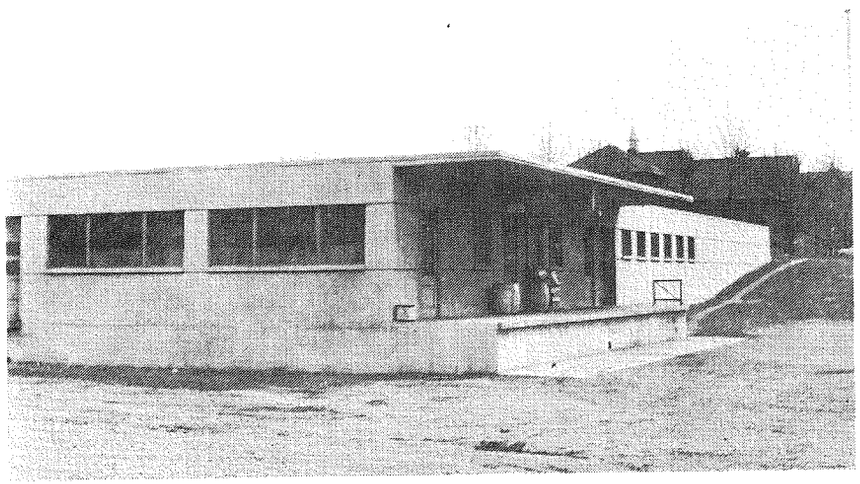
included 38 counties with a total population of 651,898. Dr. John M. Anderson served as superintendent from July, 1951, to November, 1952. Following his resignation, the clinical director, Dr. Iverson Clark Case, assumed the duties of acting superintendent until January 6, 1954, at which time Dr. Alfred Paul Bay became superintendent. The present authority of the hospital was under the Division of Institutional Management. The hospital census was at approximately 1,400. In July, 1952, Topeka State Hospital's "5-Year Training Program" for psychiatric residents was instituted. The Children's Services continued to grow, and

. . . the school at C-Cottage opened . . .

on October 4, 1952, the school at C-Cottage opened with desks, tables, and teachers. Numerous physical repairs were being made throughout the hospital as were necessary. The Old Pines Building was razed. One floor of the new commissary warehouse was opened for use in the latter part of 1952. Extensive dietary equipment repairs were made. As of June 30, 1954, 817 persons were employed at this hospital. There were concerns expressed by the State Board of Health of the arrangement of the milking barn, the milking equipment and the processing equipment, none of which met modern sanitation standards. Public Health authorities also complained that the dairy was too close to the hospital buildings and kitchens. These concerns were expressed in the 1951-1952 biennial report, but there was not mention made in the 1953-1954 report.



A-Kitchen (now Pre-preparation Kitchen) remodeling.



First floor of Commodity Warehouse.

Years 1955-1956—The hospital's function was to restore patients to mental health with a minimum of interference with their normal family and community relationships. Whenever it was possible, patients were treated while they lived at home, but they were hospitalized when necessary. To enable the hospital to obtain personnel to provide the care necessary for the patients, and to provide staff members for the other State institutions, training programs in all the disciplines of mental

health were made a secondary function of the hospital. A temporary Auditorium was built during this period, although not mentioned in this report specifically. This Auditorium still stands today.

Years 1957-1958—It had now been 10 years of progress since the hospital was converted from a custodial institution into an active treatment unit for the mentally ill. In 1948, Kansas ranked second from the bottom among States in the care of the mentally ill. In 1958, Kansas attained first place in adequacy of physician staff, and second in maintenance expenditure per patient day, but it ranked seventeenth in the cost to tax payers. Much of the credit for the gradual evolution and refinement of the changes belonged to the Staff of the Menninger Foundation in Topeka. The average patient population in fiscal year 1958 stood at 1,315. A "Day Hospital" was developed. For the first time in the history of the hospital, there was a physician for each ward.

Years 1959-1960—In 1951, an adolescent unit, and in 1959, a pre-adolescent unit became a division of the Topeka State Hospital known as the Kansas Treatment Center for Children. The latter provided residen-

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. . . The New Eastman Section was opened on August 1, 1960. . . .

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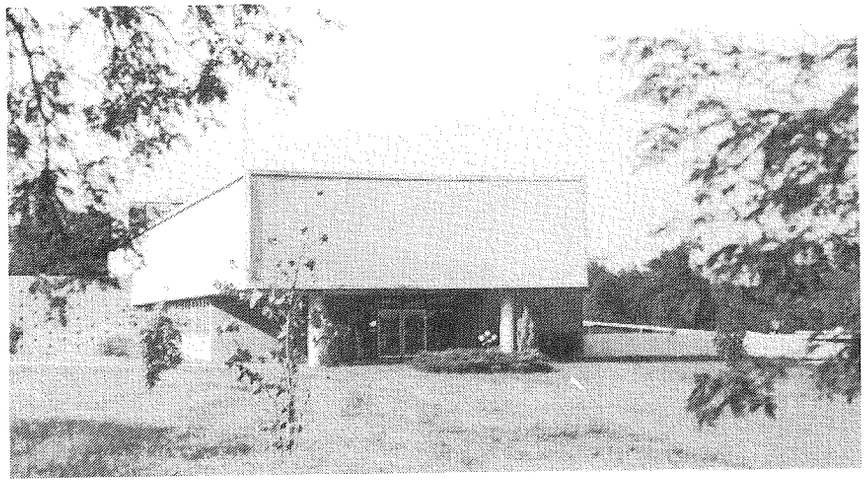
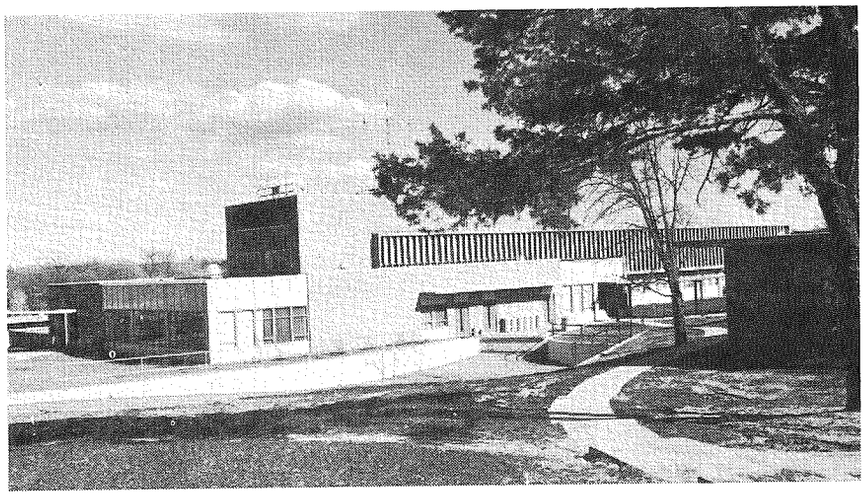
tial treatment for all of the psychotic or severely emotionally disturbed children between the ages of six and sixteen years from the entire State. Since 1959, the tuberculosis—mentally ill of the entire State had been concentrated at Topeka State Hospital. During the fiscal year 1958, Kansas was far behind other States in salaries offered to mental health personnel. Low salaries, plus overwork, induced one-half of the staff psychiatrists and other professional personnel to seek employment in other States. In 1960, the State Legislature slowed this mass exodus somewhat when authorizing an upward adjustment of salary ranges. The new Power Plant and Laundry are now in operation.

Years 1961-1962—An increasing understanding of that aspect of mental illness which deals with the breakdown in the relationship between the patient and his associates had an inevitable impact on the function of the hospital. The patient movement had been the greatest in the history of the hospital in admissions and separations. There had been an increasing reliance upon the community to supply activities for patients. The New Eastman Section was opened on August 1, 1960. The grounds and building maintenance was probably the best in the history of the institution. Building renovations took place in Biddle Hospital Building. As of June 30, 1962, the resident population was listed at 1,037.

Formerly Kansas Treatment Center for Children—later became a part of the hospital and houses now the Pre-Adolescent Unit of the Section for Children's Services.

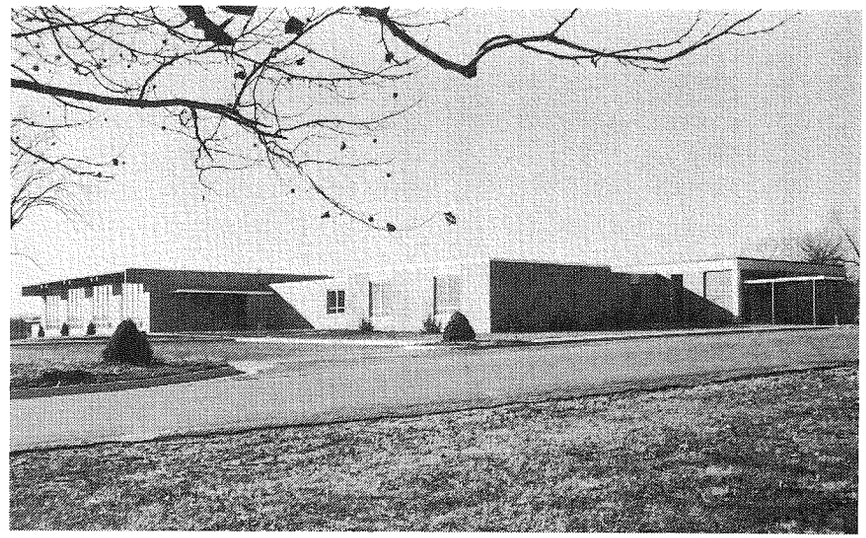


New Eastman Section.

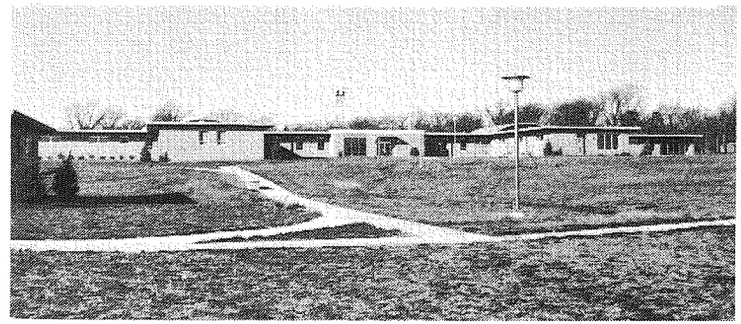


Years 1963-1964—During this period the organization of Topeka State Hospital was set up under the Kansas Plan, whereby each adult Section was assigned to admit and treat patients from specified counties, called a district. Construction was nearly completed on the New Woodsview Section. The training program initiated at Topeka State Hospital fourteen years before was now nationally recognized as one of the outstanding training programs for all disciplines related to the care of the mentally ill. At the end of this report period there were 957 patients.

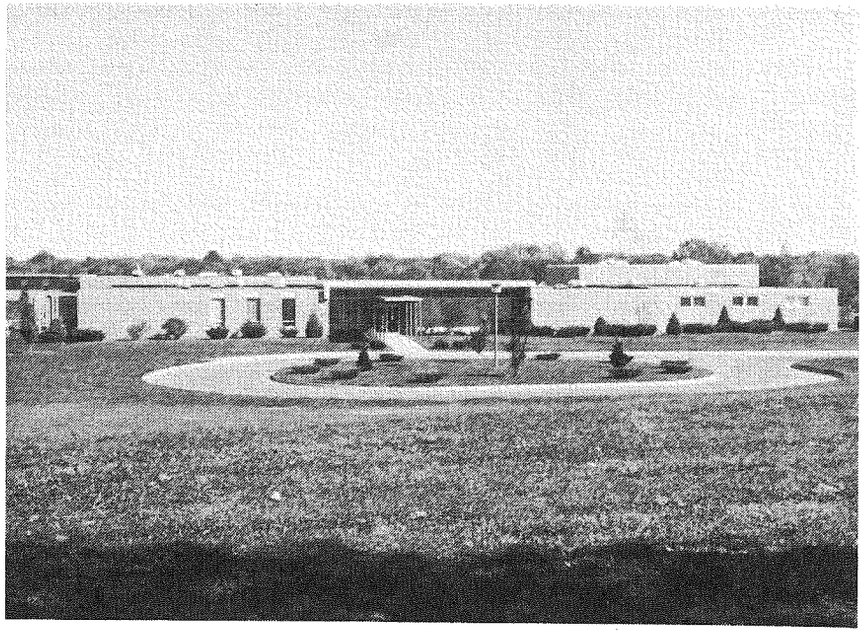
Years 1965-1966—The goal of providing a comprehensive range of mental health services for Kansans who live in the Topeka State Hospital District was accomplished in April, 1965, with the opening of the Day Treatment Service. It was noted that about thirty percent of the admissions were young patients with complex family situations. The resident population was listed at 896.



New Woodsview Section.

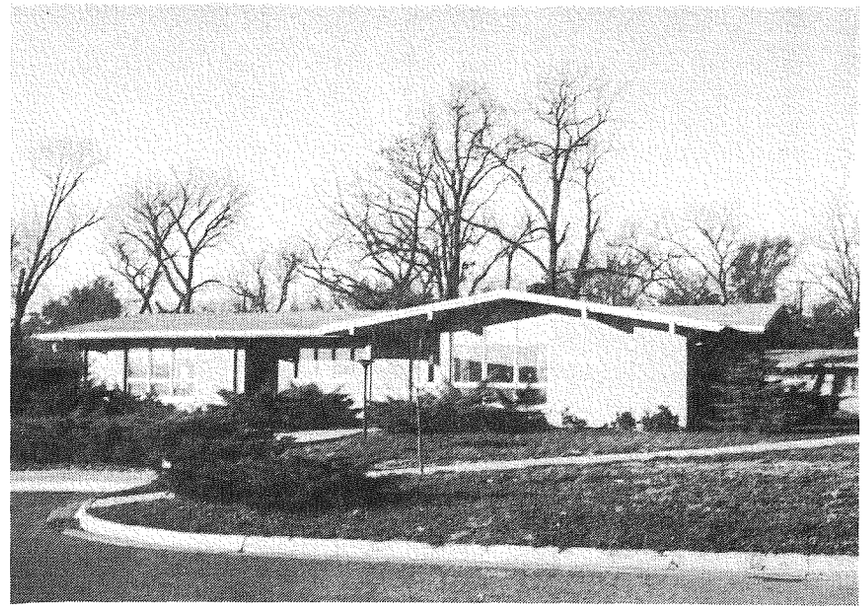


Patient units on New Woodsview Section.

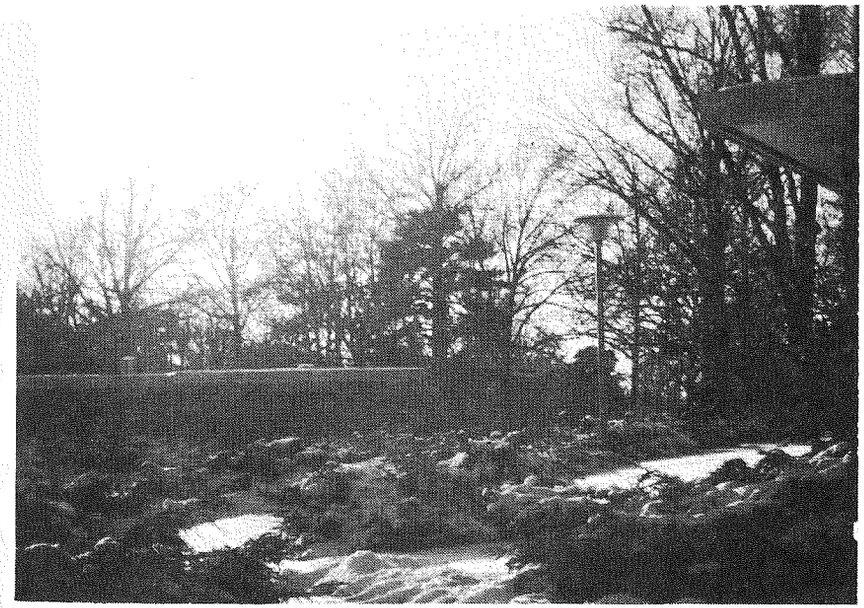


Slagle Building.

Years 1967-1968—Decreases in the average number of patients in the hospital at one time caused many changes in the application of the Kansas Plan of hospital organization. Five counties in the Topeka State Hospital District were transferred to the Larned District on September 1, 1966: Phillips, Rooks, Rice, Smith and Osborne. In November, 1966, Topeka State Hospital went from a four-section hospital to a three-section hospital. Stone Section merged with Biddle Section and the remaining counties were re-distributed so as to equalize the load for the three sections. In January, 1968, Leavenworth County was transferred from the Osawatomie State Hospital District to Topeka State Hospital. In the Fall of 1966, the Topeka State Hospital announced creation of the Division of Extramural Psychiatry. This division originated out of the need for further development of community mental health services; and the need for coordination of two extra-mural services of the hospital; the outpatient clinic and the day treatment programs. The Alcoholism Program was established. A day nursery for pre-school children was added to the Division of Extramural Psychiatry in September of 1967. The hospital instituted a program of Special Services for Maturational Training. The program goal was to help adolescents deal with the difficulties they face in the complex process of growing up. Almost sixty-five percent of all the patients were discharged in four months or less. Makeup of the patient population was changing. The highest percentage of new patients was from 15-24 year age group.



The Erickson Units house the Maturation Program and the Transitional Living Program.



Kirkbride Unit originally housed the Alcoholism Treatment Unit and now houses theTraining for Living in the Community Program.

Years 1969-1970—Long-term goals of the hospital included the care and treatment of patients; the training of individuals participating in mental health care; research, and distribution of information concerning mental health coupled with public education and the development of community resources toward providing more and better services. To accomplish these tasks, the activities and programs of the hospital were divided into three categories; Clinical Services; Research and Education, and Administrative Services. More and better educational facilities for the young patients were being established during this time. The school also began a pilot program in preventive psychiatry. Fifteen children too ill to attend regular classes in Topeka schools attended special education classes at the hospital as day hospital patients. Through this program, they were able to attend school while living at home with their families. The school library was established through a Federal grant and through the grant the school was able to hire a full-time librarian and purchase reference books and textbooks. In July, 1969, a $75,000 three-year staff development grant was awarded to Topeka State Hospital by the National Institute of Mental Health, and in-service training programs were developed. Continued expansion of the Alcoholism Treatment Program was noted, with an appropriation of the 1969 Legislature of $65,000. Vocational Rehabilitation services at the hospital were expanded. The Woodsview Section of Topeka State Hospital became a comprehensive section designed to provide inpatient, outpatient and day treatment services for the citizens of Shawnee County on July 1, 1968. This reorganization also included training for first and second year psychiatric residents. Every effort was made to coordinate the integrated Woodsview's facilities into the Shawnee community Mental Health Corporation, and still retain the Section's identity as a component of the hospital. A preschool nursery project was greatly expanded. The Special Services Section moved from the old "Stone" buildings because of their extreme fire safety hazard. Only two wards remained in the old buildings.

Years 1971-1972—Topeka State Hospital had a bed capacity of 545 beds; a complex institution with several goals. First and foremost, the goal remained to provide evaluation and treatment of psychiatric patients, primarily from the thirty counties of Northeast Kansas. A second task was the education and training in mental health care of individuals from many disciplines. Other goals were research, mental health education, and consultation to the community. Many changes in personnel took place during this biennium. The present superintendent, Dr. Eberhard G. Burdzik, took office on February 6, 1971. The most extensive organization change was the consolidation of Biddle, Eastman, and Woodsview Sections into one broad service now called Combined Services in June, 1971. The trend continued toward younger patients. The inpatient population stood at 505. Modernization of the Laundry Department equipment took place and the laundry service had been extended to the

Kansas Neurological Institute. The Tuberculosis Cottage was razed in May, 1970, and the Stone Section, last of the Kirkbride-style Wards remaining in Kansas was currently undergoing demolition. The Education Building was damaged by a fire in the Staff Library in May, 1972. Both the Library and the Department of Nursing Education were moved to expanded, more adequate quarters in Perry Cottage (formerly D-Cottage). The Capital City School (located in the former Employees' Dormitory—old), now fully accredited, carried on its program for youth in the hospital and the community with the aid of over $200,000 in Federal Title I funds. Title II funds totaling over $2,000 aided the Capital City School Library. Accreditation of Topeka State Hospital by the Joint Commission on the Accreditation of Hospitals in fiscal year 1972, confirmed and documented the high standard of hospital clinical and administrative practices. Such accreditation is also a pre-requisite for certain grants, third-party payments, and the training programs of several departments.

Years 1973-1974—The basic treatment philosophy emphasized understanding an individual's illness, consideration of resources for help in the hospital and community, and the planning and execution of an individualized treatment program to meet specific needs. This hospital was a 506-bed facility. Training programs continued as an integral part of Topeka State Hospital's over-all program. The Topeka State Hospital Research Program evaluates specific aspects of treatment programs and general hospital operations to examine their effectiveness and to open the way for development of new treatment modalities. Topeka State Hospital was organized into six administrative units: clinical services, educational services, research, personnel, administrative and public information. A major change affecting the hospital was the re-organization of the Department of Social Welfare into the Department of Social and Rehabilitation services. Locally this brought about certain physical changes, namely the move of the Regional Social and Rehabilitation Services Office into Biddle Building and the placement of the SRS District Office into one of our former Employees' Dormitories. The Adolescent Unit of Children's Services was moved into the Ray Wards (part of Eastman Complex) from the Klein and Simmel Cottages (formerly B and C Cottages) so that all patients were housed in fire-safe buildings constructed no earlier than 1960. Awl Ward was remodeled to accommodate youth offenders in a secure, intensive care setting, and a new treatment program was drawn up for this type of patient. (Awl Ward is part of the Eastman Complex.) Several staff changes were made, as well as a number of physical improvements. Dr. Burdzik remained as superintendent.

Years 1975-1976—A major effort was made to maintain an effective liaison between Topeka State Hospital and the nine (9) community mental health centers within the 31-county catchment area (Sedgwick

County was added to this district). Two major developments which would affect operation in the coming years were the implementation of procedural changes to meet the demands of the new mental health law and an administrative re-organization which involved the shifting of certain clinical positions to administrative roles, with the addition of some new positions. The new mental health law narrowed the conditions which justified involuntary hospitalization and codified certain patients' rights. It also included a periodic court review of all involuntary mental patients and required additional reports and communications be made to the courts and to the attorneys of patients. During the past two years several more Social and Rehabilitation Services agencies moved into vacant areas in the Biddle Building.

Years 1977-1978—Topeka State Hospital is a 433-bed public mental hospital, full accredited by the Joint Commission on Accreditation of Hospitals, serving a 31-county catchment area in Northeast Kansas, the hospital provides evaluation and treatment of psychiatric patients, multidisciplinary professional education and community education and consultation. The hospital is presently organized into five administrative units under the supervision of the Superintendent: clinical services, research and education, administrative services, personnel and volunteer services. The Clinical Services include: The Combined Services Section which offers general psychiatric services for adult inpatients; the Special Services Section which provides special treatment programs for teenagers and late adolescents, difficult-to-manage or court referred patients, and patients who need assistance in re-integrating into the community after a period of hospitalization; the Children's Services Section which provides inpatient treatment for severely emotionally disturbed pre-adolescents and adolescents, as well as outpatient services and a day-care treatment center for infants and pre-school youngsters; A 19-bed Medical Services Unit which cares for those patients who are also physically ill; Capital City Schools, a fully-accredited K-12 educational program on the hospital grounds, which offer special education for hospitalized youth and youth from the community; A Therapeutic Work Center; A 15-bed Youth Rehabilitation Center Unit and a 15-bed Unit for Temporary Lodging of non-psychiatrically ill youngsters awaiting permanent placement into the community. In recent years the average daily census of the hospital has substantially declined (352 in fiscal year 1976 to 334 in fiscal year 1977). The admission rate has slightly increased (1,303 in fiscal year 1976 to 1,335 in fiscal year 1977). A large number of patients continue to be referred for treatment at the hospital, but their length of stay has been reduced.

out of the
pages of history . . .

Came Boston Corbett

ALMOST interesting fact: The Story of Boston Corbett, the man who shot down John Wilkes Booth, assassin of President Abraham Lincoln, in a burning barn in Virginia.

It was before dawn on the morning of April 26, 1865, twelve days after the tragic Good Friday when the Great Emancipator was killed as he sat in the Presidential Box in Ford's Theater in the National Capital. The assassin was known from the moment he leaped from the President's Box to the stage, brandishing the Derringer he had just fired and a knife. He limped into the wings before a horror-stricken audience, too shocked to take action; his spur had caught in the flag draped in front of the box and the stumbling Booth fractured an ankle bone.

But he got away safely with the aid of an accomplice at the alley door, who had saddled horse ready. His route led to the South, where he hoped in vain to find refuge.

All available members of the armed forces and police were put in pursuit under the orders of Edward M. Stanton, Secretary of War, who personally assumed command. A unit of cavalry caught up with the fleeing assassin and his companion, surrounded the barn in which they had hidden, and ordered them to come out. The companion did so but Booth held back, and the barn was set afire.

Stanton had expressly ordered that Booth be taken alive if possible. But peering through a crack in the blazing wall of the barn was a strange character, a soldier, Boston Corbett. In direct disobedience of orders,

. . . something of a fop. . . .

Corbett cocked his rifle and awaited an opportune moment. When Booth made a movement toward the door, Corbett fired. Booth fell. It is not certain to this day whether he was the victim of Corbett's bullet.

Corbett was an engima, even to his closest acquaintances. This strange and baffling man was born in England, in 1832, and was taken to the United States by his parents at the age of 7 years. His real name was not Boston, but Thomas. He was a small man, well dressed, something of a fop. He was a hard worker and became a skilled hat maker in Danbury, Connecticut.

And then, something happened that changed the course of his life; he converted to religion. He was no casual convert; he became a passionate believer.

He changed his name because the Disciples of Christ changed theirs on their conversion. He began to wear his hair long, became careless in his dress and organized and conducted prayer meetings among his fellow workmen. Men who had been friendly shunned him when his activities took a fanatical turn.

When the Civil War broke out he was one of the first to answer Lincoln's call for volunteers. Bible in pocket and rifle on shoulder, he marched away to the war. He re-enlisted three times on the expiration of his terms, and he proved his bravery in action.

His religious zeal increased. Even when he was captured and sent to Andersonville Prison, he organized prayer meetings. He was released when the war ended and made his way back to Washington, soon to become a major actor in one of history's greatest tragedies.

Corbett was the first soldier to volunteer for the military posse dispatched in pursuit of Booth. Boston pleaded with his commander to be allowed to enter the barn and bring the assassin out. His request was refused.

When Booth was slain, perhaps by Corbett's gun, he expected promotion, at least. Instead, he was arrested for disobeying orders and thrown in the guard house on the return to his squad in Washington. He found himself criticized by the military and the people for taking the law into his own hands.

He was not placed on trial but was released to rejoin his outfit, the men of which would have nothing to do with him. He applied for the reward of $5,000 offered for the capture of Booth. After many months of delay, he was given $1,653.48 by Congress.

Corbett became a brooding misanthrope, misunderstood and rejected, pointed out as the man who prevented the assassin from being tried and executed properly. He sought relief in his religion, walking the streets of Washington at night, shouting for salvation in the ears of passersby. He joined the Salvation Army.

At last, incensed at his treatment, he "went west" as so many of the veterans were doing. He chose Kansas, where he built a sod house on an 80-acre claim in Cloud County in the early 1870's. Then he tried unsuccessfully to raise sheep.

At last he received an appointment as a sergeant-at-arms at the State Capitol in Topeka. Proud of his new authority, he strapped an Army revolver about his waist and assumed his new duties. He took them very seriously. He would interrupt Legislative Sessions with abrupt and

loud orders for quiet. He let his beard grow and was pointed out to visitors as the man who avenged Lincoln.

There was one memorable occasion when Corbett "adjourned" a Session of the Legislature at the point of his revolver. He had arrived ready for duty one morning, his weapon strapped to his side, when he found some unauthorized visitors lounging about the Session room

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. . . He chose Kansas, where he built a sod house on an 80-acre claim in Cloud County in the early 1870's. . . .

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and two doorkeepers, a number of clerks and pages and other employees holding a meeting and shouting for "Mr. Speaker." Corbett listened a while until the "speaker" announced that "The Reverend So-and-So, will now invoke a blessing." This was too much for the deeply religious little man.

From the vantage point of the gallery he ended the "blasphemy" by ordering the room cleared. The story grew with time and eventually had him adjourning a regular Session of the Legislature.

This Act resulted in his arrest, but through the efforts of his attorney, Charles Curtis, was adjudged insane. The attorney lived to become Vice-President of the United States under Herbert Hoover. Corbett was locked in the State Insane Asylum in Topeka, Kansas.

He escaped after he had been confined a little more than a year, on a pony. It is said he headed in the direction of Mexico.

A statement issued on his escape read as follows:

INSANE MAN ESCAPED

Topeka, Kansas
May 26, 1888

Dear Sir:

BOSTON CORBETT, an insane man, escaped from the Insane Asylum at Topeka this morning, and is supposed to be heading for Cloud County. He is about 55 years of age: about 5 feet, 1 inches high; has plucked all his beard out down to the lower part of his ears; has gray chin whiskers and moustache; gray hair, cut square at bottom, and parts his hair in the middle; he wore a dark jeans suit, a black soft hat; and was riding a bay or sorrel pony with a boy's saddle.

He is regarded as a dangerous man, but was unarmed when he escaped. If he comes your way arrest him and return him to the Asylum at once, or telegraph Dr. B. D. EASTMAN, Superintendent, Insane Asylum, Topeka, for orders.

G. A. HURON.
Guardian Boston Corbett.

That was the last time Boston Corbett was seen. Rumors rose and grew. One of the most improbable was that he met a man in Mexico who turned out to be John Wilkes Booth, and that he had to kill the assassin again. Some versions had Corbett the victim of the encounter.

One thing apparently is certain. Boston Corbett was not made "queer" by his part in the sensational killing in the burning barn. He had been unbalanced a long time before that. He was always proud of his role of avenger; he even boasted that he took pains to aim at his victim so that the bullet would enter behind the ear in the same place Lincoln was shot. This would, indeed, be marksmanship. Corbett scorned the inference that it was a coincidence. "God directed that bullet," he insisted.

How the Buildings Got Their Names

THE WOODSVIEW Section was named originally Stone Men. A contest was held among the patients on that Section. Because of the many trees in the area of this building, one of the male patients selected "Woodsview" which was judged the winner. Dr. Karl A. Menninger presented a small gift to the patient at the dedication of "Woodsview" Section on Arbor Day in 1950. At this ceremony the flowering crab apple tree which is just east of the Administration Building was planted.

Woodsview Section (Section for Adult Services). This new complex of buildings was opened in February, 1965. The various buildings were named in honor of the following:

SOUTHARD, Elmer Ernest, M. D. (1876-1920) Psychiatrist. Elmer Ernest Southard received his medical training at Harvard University and his prominence was gained largely at the Psychopathic Department of Boston State Hospital, of which he became director in 1912 when the institution was opened. His greatest contributions were as clinician and teacher. Among his students was Dr. Karl A. Menninger of Topeka. Dr. Southard was assistant editor of the Journal of Nervous and Mental Diseases, the Psychiatric Bulletin and the Journal of Clinical Laboratory and Medicine. (The Southard Building serves as the Section Administrative Offices, and Cafeteria for the Adult Services Section.)

JARRETT, Mary Cromwell, (1876-1961) Psychiatric Social Worker Mary C. Jarrett, educated at Goucher College, Baltimore, Maryland, was a teacher and tutor before beginning her social work career at the Boston Children's Aid Society. In 1913, Dr. Southard appointed her Chief of the newly created Social Service of the Boston Psychopathic Hospital. Dr. Southard and Miss Jarrett collaborated in the first book on psychiatric social work, *The Kingdom of Evils.* Her article, *The Psychiatric Thread Running Through All Social Case Work,* has had continuing significance for social workers. (The Jarrett Building houses adult inpatients on the Section for Adult Services.)

SLAGLE, Eleanor Clarke (1876-1942) Occupational Therapist. While a student at the School for Civics and Philanthropy at Hull House, Eleanor Clarke Slagle visited Kankakee State Hospital, Illinois, and noted the idleness of patients. Soon afterwards, and through her influence, in 1908, the first training course in occupational therapy was conducted

at Hull House. Through her work, and in 1922, Mrs. Slagle, with Mr. T. B. Kidner, Dr. William R. Dunten, and others formed the American Occupational Therapy Association. (The Slagle Building houses the Activity Therapies Department.)

RAPAPORT, David, Ph.D. (1911-1960) Clinical Psychologist. Dr. Rapaport was born in Munkacs, Hungary, and was a staff psychologist at the Osawatomie State Hospital from 1939-1940. He then joined the staff of the Menninger Foundation, first as a staff psychologist and then as head of the Psychology Department from 1942-1946, later becoming the Director of Research from 1946-1948. Dr. Rapaport left the Menninger Foundation in 1948 to become a research associate at the Austin Riggs Foundation in Stockbridge, Massachusetts. He wrote the Diagnostic Manual which was utilized as a springboard for development of methods utilized by psychologists in the Armed forces during World War II. Sometime later, he and others wrote and published the more elaborate two-volume *Diagnostic Manual,* which was utilized throughout the world as a basis of maximizing the psychologist's contribution to the team process of diagnosis and treatment. (The Rapaport Building houses adult inpatients on the Section for Adult Services.)

BOISEN, Anton T., (1876-1965) State Hospital Chaplain. The Reverend Anton T. Boisen, born in Bloomington, Indiana, was educated at Indiana University and Union Theological Seminary, New York City, served as pastor of the "Beecher Bible and Rifle Church" Wabaunsee, Kansas. Recovering from a severe psychosis which necessitated hospitalization, Chaplain Boisen entered a period of graduate study. At Harvard University, he did research work on the relationship of religious experience and mental illness. In 1924, he became the first Mental Hospital Chaplain. In 1925, he established the first program of Clinical Pastoral Training in the United States and in 1930, he helped to incorporate the Council for Clinical Training. By many students he was affectionately called "The Father of Clinical Pastoral Training." In a distinctive manner Anton T. Boisen was the first clergyman to work as a member of a Psychiatric Team. (The Boisen Building houses adult inpatients on the Section for Adult Services.)

ERICKSON, Isabel (1908-1958) Psychiatric Nurse. Isabel Erickson trained as a nurse at Christ's Hospital, now called Stormont-Vail here in Topeka. Upon graduation as valedictorian in 1933, she became chief nurse at the Menninger foundation. She worked there until a serious cardiac lesion forced her to give up this strenuous work in 1944. Under her tutelage at the Menninger Hospital one of the earliest training programs in psychiatric nursing which stressed the team concept was developed. She taught by example the importance of close team work in treatment of the mentally ill. From a bequest Miss Erickson left to the Menninger foundation, an award was to be given to the outstanding

student nurse in each class trained at Topeka State Hospital. (The Erickson Unit today, is part of the Special Services Section and consists of the Maturation Unit and the Transitional Living Program.)

The Eastman Complex now houses a portion of the Section for Special Services and also a portion of the Section for Children's Services. The Eastman Building itself was, of course, named for Dr. B. D. Eastman, the first Superintendent. This complex also houses the Pharmacy, Medical Records, the Admissions Office, the Cafeteria, Volunteer Services and the Information Center of the Hospital.

The remaining buildings in this complex were named after outstanding early American Psychiatrists. Five of the original "twelve founders" of the American Psychiatric Association were chosen to be memorialized in this new section.

RAY, Isaac, M. D., was born in Beverly, Massachusetts, on January 16, 1807. He graduated from Harvard Medical School in 1827. He became interested in the legal aspects of mental disorder, and in 1838, published his "Medical Jurisprudence of Insanity." He practiced medicine in Maine, and following visits to Europe he returned to superintend the construction of the Butler Hospital in Providence, Rhode Island, in 1847, and remained at this institution for the next twenty years. during which he demonstrated his ability as an able and progressive administrator. He was a frequent contributor to legal and medical journals throughout his career. (The Ray Building today houses the Adolescent Unit of the Section for Children's Services.)

BRIGHAM, Amariah, M. D., was born in New Marlboro, Massachussetts, December 26, 1798. He studied medicine with physicians in Massachusetts and Connecticut, and began the practice of medicine in 1821. His interest in mental illness appears to have been gradual in its development, but by 1837, he had published a book and several treatises relating to the manifestations and treatment of mental illness. In 1842, he was appointed superintendent of the State Asylum at Utica, New York—the first state institution authorized in that State. During his administration the asylum became known as "the training place for superintendents." His administration was progressive, and it was said in reminiscence that "under Dr. Brigham no means were unthought of and untried." "By his systematic writing, he prepared the public for the awakening to the claims of the insane." (The Brigham Building presently houses the Youth Rehabilitation Unit, the Unit for Temporary Lodging and a Unit for Adolescent Children.)

AWL, William Mcclay, M.D., was born in Harrisburg, Pennsylvania, on May 24, 1799. he was a product of the apprentice system though there is record that he attended one course of medical lectures at the University of Pennsylvania in 1819. In 1826, Dr. Awl began the long

journey to Ohio on foot, and practiced in several cities, finally settling in Columbus in 1833. He was forcefully struck by the lack of facilities for the care of the mentally ill, and was active in securing authorization from the Ohio Legislature to erect a hospital. He was one of the trustees commissioned to supervise its construction, and in 1838, was appointed its superintendent. He is described as a man of great force of character, of originality, of knowledge of the world, a man who had a choice sense of humor and sound common sense, and he stood in high regard among the founders of American psychiatry. (The Awl Unit is the most secure unit in the hospital, which serves the more hard-to-manage patients.)

WOODWARD, Samuel B., M.D., was the first president of the American Psychiatric Association, born in Torrington, Connecticut, June 10, 1787. He studied medicine with his father, and was licensed to practice at the age of twenty-one. Early in his practice the difficulties of management of the mentally ill in their own homes were impressed upon him, and with a few others he was active in the establishment of the "Retreat" at Hartford. In 1832, Massachusetts became the first New England State to establish a State hospital, and Dr. Woodward was elected superintendent. Dr. Woodward's methods were progressive, and he was interested in the moral as well as the medical treatment of patients. Those who came in contact with Dr. Woodward were impressed by his hopeful spirit, his grace and dignity, and his great kindliness. (The Woodward Building houses the Medical Services Unit and the Allied Clinical Services.)

KIRKBRIDE, Thomas S., M.D., was born in Morrisville, Pennsylvania, July 31, 1809. Dr. Kirkbride was a Quaker. He studied under a French physician who had accompanied Lafayette to America, and later studied at the University of Pennsylvania. He served a year as resident physician at the Friends Asylum, and the following year was elected resident physician at the Pennsylvania Hospital. He was shortly appointed physician-in-chief and superintendent of the new Pennsylvania Hospital for the Insane—a post in which he served with distinction for the next forty-three years. In 1854, Dr. Kirkbride published a volume on the Construction, Organization and General Arrangements of Hospitals for the Insane, a document whose principles are applicable and worthy of consideration even to this day. As early as 1841, he established rule books for "attendance", and he was an early advocate of minimal restriction. He instituted hospital newspapers, and advocated excursions, lectures, entertainments, and industrial therapy for patients. (The Kirkbride Buildings house the Training for Living in the Community and the Dental and Eye Clinic and soon a hospital canteen.)

PERRY, M. L., M.D., was Superintendent of Topeka State Hospital from 1918 until 1948. Dr. Perry was born in Texas and began his hospital

internship in Virginia a year after graduation from the University of Tennessee in 1882. His first assignment was as an assistant physician in the New Jersey State Hospital in 1894. He came to Kansas in 1903, and served as superintendent of the State Hospital for Epileptics at Parsons for 15 years prior to coming to Topeka State Hospital. (Perry Building today houses the Staff Library and the Nursing Education Department and also other Social and Rehabilitation Services' offices.)

BIDDLE, Thomas C., M.D., was born in Putnam County, Indiana, on September 14, 1857. Dr. Biddle attended the district schools, and afterwards was a student in Old Asbury, now DePauw University at Greencastle, Indiana. For his professional course, he attended Rush Medical College in Chicago, where he was graduated M.D. in 1881. Upon coming to Kansas, he first located at Reading, where he practiced medicine six years, then was in practice at Emporia for eight years and from there was named to the superintendency of the State hospital at Osawatomie for three years. On April 27, 1898, Dr. Biddle was commissioned physician and surgeon in the famous Twenty-first Kansas Volunteer Infantry. He went with his command to Chickamauga Park, and was then transferred to the Reserve Hospital of the First Army Corps and sent to Puerto Rico. From there he was ordered home in November to join his regiment to be mustered out and was honorably discharged at Fort Leavenworth on December 10, 1898. After this brief military experience Dr. Biddle returned to Emporia. On April 1, 1899, he was appointed superintendent of the State Hospital for the Insane at Topeka, and served in that position 19 years. In point of service, he was one of the oldest superintendents of hospitals for the insane in the United States. Dr. Biddle was a member of the American Psychological Association, Lyon County Medical Society, the Kansas State Medical Society and the American Medical Association. (The Biddle Building presently houses the Vocational Rehabilitation Unit and other Social and Rehabilitation Services' offices.)

FELDMAN, Paul E., M.D., was Director of Research at Topeka State Hospital from 1955, until his death on February 28, 1968. Due to Dr. Feldman's work in the field of research, a large donation was received from various pharmaceutical companies as well as fellow co-workers in his memory. The contributions received were used to build the fountain and sculpture in front of the Southard Building. Inasmuch as Dr. Feldman was at one time during his service responsible for psychiatric residency training, the remaining contributions were used to purchase video tape equipment. (The former "F" Cottage built in 1930 was later renamed "Feldman Cottage" in memory of Dr. Feldman and now houses the Children's Outpatient Services and the Child Development Center, as well as other Social and Rehabilitation Services' offices.)

SIMMEL, Ernst, M.D., (1882-1947) Psychiatrist. Dr. Simmel was born in Breslau, the youngest of nine children, and grew up in Berlin. He received his medical training in Berlin, and in Rostock, Germany. His doctor's dissertation (1908), the first of a long list of scientific papers, bore the title: "A Critical Contribution Concerning the Psychogenesis of Dementia Praecox." For this work he was awarded the Freud prize in 1918. He was one of the founders of the Berlin Psycho-Analytic Institute and established an institute to train psychiatrists in psychoanalysis in California and organized the San Francisco and Los Angeles Psychoanalytic Societies. He introduced and conducted the first psychoanalytic seminars for teachers and social workers, and eventually evolved a program to train psychiatrists in psychoanalysis. (The Unit named in his honor, Simmel Boys and Simmel Girls, houses adolescent patients in the Ray Building.)

KLEIN, Melanie, was born on March 30, 1882, in Vienna. With the death of Melanie Klein in London, in 1960, psychoanalysis lost a great and controversial figure. She was the pioneer of child analysis and in the course of her profound and original work she opened the way to the understanding of the mental processes which dominate the infant mind. "Envy and Graditude" was written only four years before her death and two years after that she completed "Narrative of a Child Analysis." Melanie Klein, was and considered herself first and foremost a strict follower of Freud. (Klein Cottages today house adolescent boys and girls and is located in the Ray Building.)

The Buildings in the Pre-Adolescent Unit were named for the following people:

AICHHORN, August, M.D. (1878-1949) Psychiatrist. Dr. Aichhorn turned to the study of psychoanalysis after the first World War when there was nothing to foretell that he was destined to become one of the significant figures in the psychoanalytic movement. He entered the Vienna Psychoanalytic Society in 1922. Aichhorn was too modest to realize that his arrival in the Society marked the opening up of a new field of application for psychoanalysis not that he had as much to offer to psychoanalysis as he could hope to gain from the study of the new science. He was an expert in his own field, a successful educator and re-educator, with abundant human material at his disposal. His first published book was "Wayward Youth" in 1925. This today is a book that is read and used as a text book not only in England and America, but in Sweden, Norway, Belgium, Holland and Hungary in dealing with child guidance and delinquency. (The Aichhorn Building serves the Pre-Adolescent Unit as the Administrative Building and Cafeteria.)

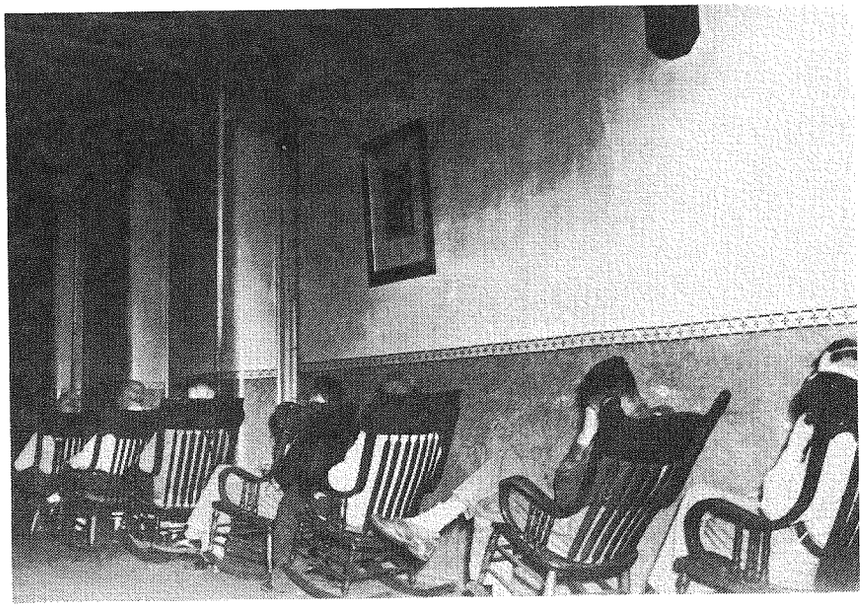
GERARD, Margaret Wilson, M.D. (1894-1954) Psychiatrist. Dr. Gerard was born in Chicago, and her life covers a half century of child psychiatry. Her scientific and human interest brought her into contact

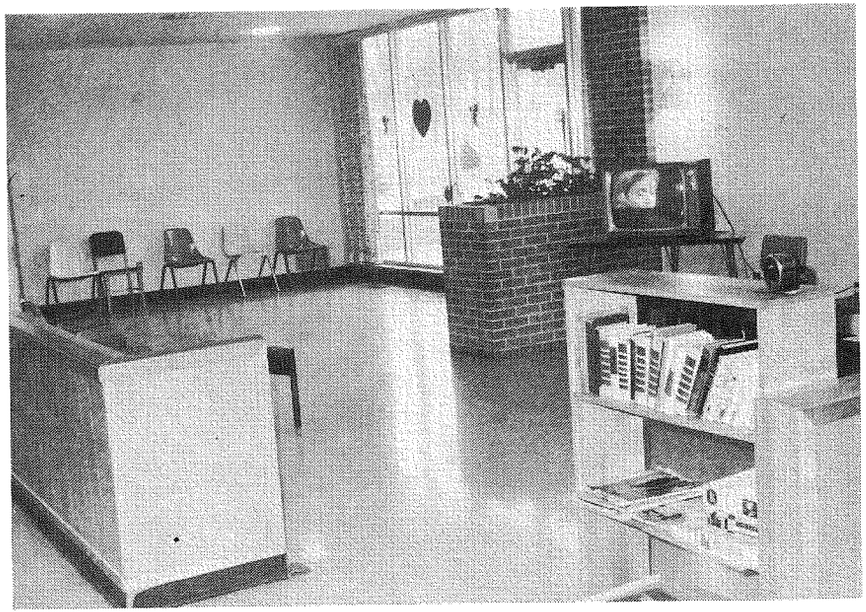
with every phase of service to childhood. As a member of the staff of the Institute of Psychoanalysis, beginning in 1936, she was one of the organizers of the Psychoanalytic Child Care Program of the Institute. She wrote many papers, and the last paper in her collection, "The Psychosomatic Concepts in Psychoanalysis" was dated the year before her death. Her "Plan for a Treatment Institution" is a symbol of her belief that no matter how badly hurt, every child can be brought to better functioning in society. In her own words, "Long experience with the use of all our healing skills has assured us that this distorted growth is not irreparable." She regarded no child as untreatable, but sought through experimentation to find methods which would help rehabilitate the emotionally destitute. (Gerard Cottage, Pre-Adolescent Unit, houses both boys and girls.)

SULLIVAN, Harry Stack, M.D., was born in New York State in 1892. He was graduated from the Chicago College of Medicine and Surgery in 1917, just in time to enter World War I. Throughout his many productive years, Dr. Sullivan emphasized the necessity for the conceptual clarification of psychiatry, and contributed invaluable insight to many hitherto unexplored areas in the treatment of mental disorder. Harry Stack Sullivan was the founder and first president of the William Alanson White Psychiatric foundation. At the time of his death, he was Editor of Psychiatry and Chairman of the Council of Fellows of the Washington School of Psychiatry. It has been said, with the passing of Dr. Sullivan on January 14, 1949, that the civilized world lost one of its most devoted crusaders for the cause of mental health and social progress. (Sullivan Cottage today houses pre-adolescent boys.)

Time Changes Everything

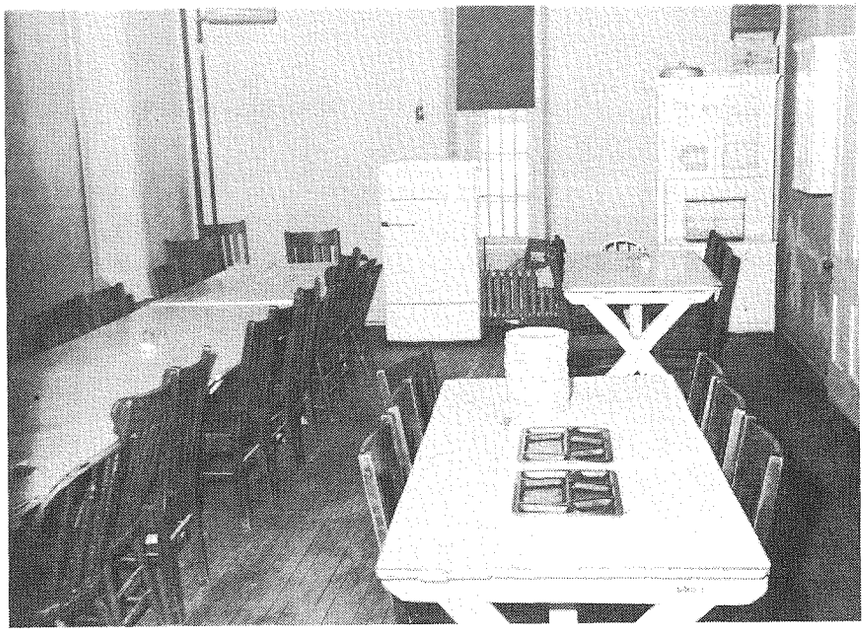
A TYPICAL dayhall of old and a typical one in the new patient buildings. These are from both the old Woodsview and the new Woodsview Sections.

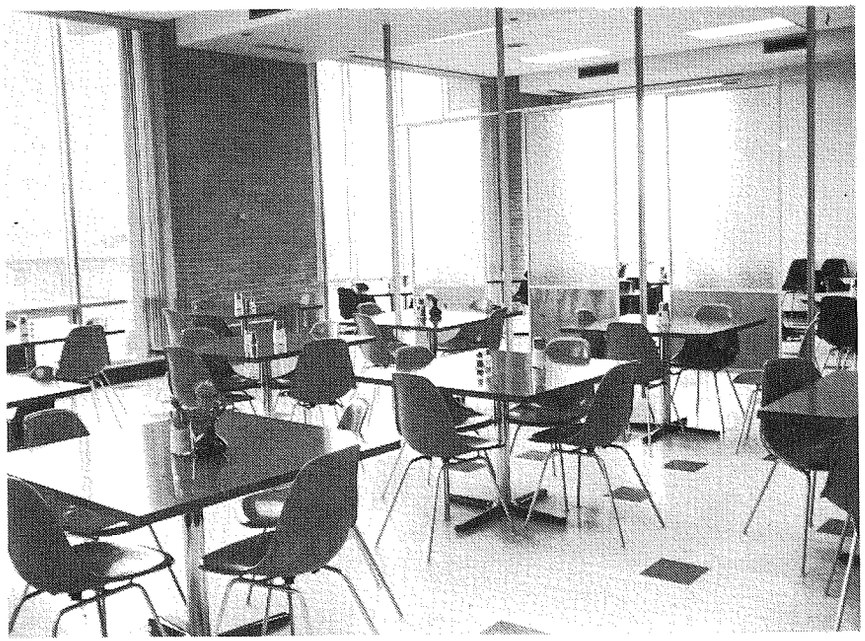


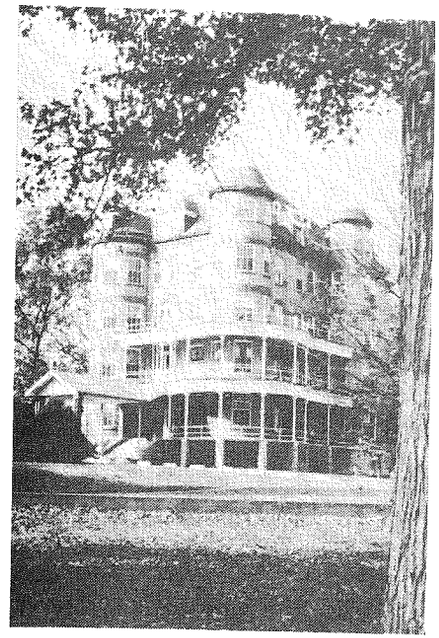


Bakery goods were once baked in our bakery as seen here. Today this bakery has made way for pre-baked items shipped to the hospital for consumption.

These pictures are contrasting—of the old and new dining rooms. These dining rooms were both in the Woodsview Section—in the old and the new.







These pictures show the old Stone and Woodsview Sections in front of which is the remaining Center Building. Today, the Center Building stands alone. The back of Center Building is connected to the only remaining part of the original buildings that were built in the late 1870's.

ONE OF THE FINEST FACILITIES

What the Future Holds

ONE HUNDRED years have now passed since the first patient was admitted to the "Topeka Insane Asylum." Many changes in treatment philosophies have taken place through these years and today finds "Topeka State Hospital" one of the finest facilities available for the treatment of the mentally ill.

Topeka State Hospital is officially a 430-bed public mental hospital, fully accredited by the Joint Commission on Accreditation of Hospitals. The hospital continues to function under the aegis of the Department of Social and Rehabilitation Services (K.S.A. Supplement 75-3303 [a]).

Serving a 31-county catchment area in Northeast Kansas, the hospital provides 1) evaluation and treatment of psychiatric patients, 2) multidisciplinary professional education and 3) community education and consultation. The hospital is presently organized into four administrative units under the supervision of the Superintendent; clinical services, research and education, administrative services and personnel.

The clinical services include: 1) The Section for Adult Services, which offers general psychiatric services for the adult patients; 2) the Section for Special Services, which provides special treatment programs for teenagers and late adolescents, difficult-to manage or court referred patients, and patients who need assistance in re-integrating into the community after a period of hospitalization; 3) the Section for Children's Services which provides inpatient treatment for severely emotionally disturbed pre-adolescents and adolescents as well as out-patient services and a day-care treatment center for infants and pre-school youngsters; 4) support programs—(a) 19-bed Medical Services Unit which cares for those patients who are also physically ill; (b) Capital City Schools, a fully-accredited Kindergarten through 12th grade educational program on the hospital grounds, which offer special education for hospitalized youth and youth from the community; and (c) a Therapeutic Work Center.

Presently, additional services have been established for youth. In response to administrative and legislative mandate and with the support of the Governor's Committtee on Criminal Administration, a Youth Rehabilitation Center has been established at Topeka State Hospital. This Youth Rehabilitation Center is a 15-bed unit for delinquent and miscreant boys who are referred by juvenile courts in the state or from other Youth Centers. Another 15-beds have been utilized for a Unit for Temporary Lodging, established in response to a need for temporary residential care, protection and secure custody for youth

committed to the custody of the Secretary of Social and Rehabilitation Services for whom no other immediate placement is available. Plans are presently being worked out to expand such a unit which is a non-medical model.

The treatment philosophy of the psychiatric services emphasizes understanding the patient's illness, identifying the sources for help within the individual, in the community, and in the hospital; and planning and implementing an individualized treatment program to meet the patients' specific needs. The professional staff works to create a therapeutic milieu through interaction of employees, patients and physical environment. The treatment team consists of psychiatrist, psychologist, psychiatric nurse, licensed mental health technicians, mental health technicians and psychiatric aides, chaplain, social worker, activity therapists, teachers, reimbursement officer, dietitian and vocational counselor.

Clinical staff provide community education and consultation in programs at the hospital and in the community, as well as hosting many lay and professional visitors. Consultation is provided for people and agencies in the community, such as clergymen, physicians, teachers, welfare workers, courts, community mental health centers, and nursing

. . . bridge the gap between the hospital and the community.

homes by the hospital staff. The purpose of these consultations is to prevent hospitalization and to encourage early referrals to prevent lengthy hospital stays, and to bridge the gap between the hospital and the community.

Educational programs are to provide a manpower-pool of trained and qualified mental health workers in all disciplines and consist of post-graduate and in-service training. Training programs are conducted for activity therapists, chaplains, mental health technicians, psychiatric aides, licensed mental health technicians, nurses, psychiatrists, psychologists, social workers, and teachers. The Topeka State Hospital Staff Library contains 10,000 volumes and 2,000 bound journals to support this learning.

The goal of the Research program at Topeka State Hospital is to evaluate treatment programs and general hospital operations in order to validate or invalidate their effectiveness, and to develop new treatment modalities.

The Outpatient (Adult) Program, the Day Treatment Program and the Alcoholism Treatment Program have been phased out over the last two years as resources became available in the communities.

The Administrative Services at the hospital maintain the facilities and operations for optimal clinical effectiveness. The administrative departments include: Accounting, Business Office, Dietary, Engineering and Maintenance, Laundry, Purchasing and Supply, Reimbursement, Security, Mail, Transportation, Pharmacy, Medical Records and the Section-Ward Manager System. The Topeka State Hospital Laundry also serves the needs of the Kansas Neurological Institute, Youth Center at Topeka and the Kansas Rehabilitation Services for the Blind.

The new mental health law narrows the conditions which justify involuntary hospitalization and codifies certain patients' rights. It also includes a periodic court review of all involuntary mental patients and requires additional reports and communications be made to the courts and the patients' attorneys.

Eligibility—All individuals who are in need of services for determinations of treatment of mental illness, and who are residents of the Topeka State Hospital catchment area. On the Section for Children's Services only children 6 years to 16 years-10 months who are seriously disturbed and in need of 24-hour, long-term hospitalization are admitted to the Adolescent and the Pre-Adolescent Units. An adolescent unit is also available for the purposes of evaluation. Limited out-patient child psychiatric services are available, primarily for the same age group.

Applications for Admission (voluntary) any individual can request and sign an application for evaluation, admission, for inpatient services provided by the hospital. For a child between the ages of 16 and 18 (voluntary by guardian admission), the child as well as the parent or guardian must sign the application. The child below the age of 16 is encouraged to sign the application although this is not a requirement. Court Order—a District Court (probate division) may issue an order for evaluation and/or treatment. Court Commitment—The probate division of the District Court may commit an individual to the hospital after determining that he/she is mentally ill and in need of treatment. With additional services to be provided for children and youth, voluntary admissions may be limited. Children may also be admitted by court order—juvenile division of the District Court.

Topeka State Hospital provides 24-hour services. Offices are open at 8:00 A.M. and close at 5:00 P.M., Monday through Friday. There is however, always an "officer of the day" (psychiatrist-physician) on call for emergencies.

Fees are computed based on services rendered. For sufficient reason, the fee may be adjusted by the hospital's reimbursement officers. Consideration can be given to other family obligations. Fees must be discussed with the Reimbursement Office staff.

Funds are from Legislative appropriations, including income from patient fees.

Looking from Center Building out to the Flag Pole.

"Finally, we would not be unmindful of the fact that all our joint success has been due to the kind, protecting care of Him who holds us in the hollow of His Hand."

B. D. Eastman, M.D.

Attachment 8

STATE OF KANSAS

OFFICE OF THE ATTORNEY GENERAL

2ND FLOOR, KANSAS JUDICIAL CENTER, TOPEKA 66612

ROBERT T. STEPHAN
ATTORNEY GENERAL

MAIN PHONE: (913) 296-2215
CONSUMER PROTECTION: 296-3751
ANTITRUST: 296-5299

July 23, 1979

ATTORNEY GENERAL OPINION NO. 79- 161

Mr. Edwin H. Bideau, III
Neosho County Attorney
123 W. Main
Chanute, Kansas 66720

Re: Criminal Procedure — Criminal History Record Information — Unlawful for Employers to Require Certain Acts

Synopsis: A person is entitled to inspect his or her own criminal history record information pursuant to K.S.A. 1978 Supp. 22-4709. However, K.S.A. 1978 Supp. 22-4710 forbids an employer from requiring an employee to make such an inspection in order to furnish the employer with a copy of the person's record. Further, an employer may not be authorized by the employee to view the employee's criminal history record information.

* * *

Dear Mr. Bideau:

You have inquired as to whether an employer may obtain a release from a prospective employee, thereby allowing the employer to view the person's criminal history record in light of K.S.A. 1978 Supp. 22-4710(a), which provides:

> "It is unlawful for any employer or prospective employer to require a person to inspect or challenge any criminal history record information relating to that person for the purpose of obtaining a copy of the person's record in order to qualify for employment."

Ex 3

The Criminal History Record Information Act, K.S.A. 1978 Supp. 22-4701 et seq., is the response of the Kansas Legislature to the federal mandate requiring a state plan for the dissemination and security of criminal records. 28 C.F.R. §20.1 et seq. (1976). The pertinent portion of these federal regulations is found in 28 C.F.R. §20.20 (1976), which provides in part:

> "(a) The regulations in this subpart apply to all State and local agencies and individuals collecting, storing, or disseminating criminal history record information processed by manual or automated operations where such collection, storage, or dissemination has been funded in whole or in part with funds made available by the Law Enforcement Assistance Administration. . . ."

In a letter of August 26, 1976, to the Director of the Kansas Bureau of Investigation, the Deputy Administrator of LEAA concluded that the Kansas plan "adequately addresses all requirements of the Regulations and is approved as submitted." Once enacted, K.S.A. 1978 Supp. 22-4701 et seq. became the controlling law in this state regarding criminal history record information. See Attorney General Opinion No. 79-98.

Inspection of one's own record of events is governed by K.S.A. 1978 Supp. 22-4709 which provides in part:

> "(a) Subject to the provisions of this act and rules and regulations adopted pursuant thereto, any person may inspect and challenge criminal history record information maintained by a criminal justice agency concerning themselves."

Further, the only person who may be authorized to inspect another's criminal history record is that person's attorney. K.S.A. 1978 Supp. 22-4709(a).

As we interpret K.S.A. 1978 Supp. 22-4710, it prohibits an employer from requiring that an employee inspect and obtain a copy of the employee's own criminal history record information, pursuant to the above quoted provision, "for the purpose of obtaining a copy of the person's record." We construe this statute as preventing an employer from having access to criminal history record information available only to the prospective employee "in order to qualify" that person for employment. Whether or not the employer states openly that a release of criminal history record information is required to qualify for a job or

Ex 3

merely requests the employee to sign a release for such information, the employee faces a paradox, either waive the privacy afforded by K.S.A. 1978 Supp. 22-4710 or risk the possible loss of a job. We believe that this statute was intended to prohibit the latter situation as well as the former. Therefore, we find K.S.A. 1978 Supp. 22-4710 prohibits an employer from circumventing its provisions through the use of a release from the employee authorizing the employer to view criminal history record information of the job applicant.

Very truly yours,

Robert T. Stephan

ROBERT T. STEPHAN
Attorney General of Kansas

Kurt J. Shernuk

Kurt J. Shernuk
Assistant Attorney General

RTS:TDH:KJS:may

Ex 3

Attachment F

AFFIRMATIVE ACTION PLAN

THE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

STATE OF KANSAS

--TABLE OF CONTENTS--

NOTE: Effective July 1, 1978, this replaces the SRS Affirmative Action Plan dated January 1, 1975.

--APPENDICES--

* Due to their volume, these items may not be attached to this copy. This information will be available upon request to the Department EEO officer.

AFFIRMATIVE ACTION PLAN
for
The Department of Social and Rehabilitation Services
State of Kansas

PART I

POLICY STATEMENT

The primary function of this department is providing services to Kansans in need of those services. If we are to perform efficiently and competently we must accept the commitment individually and collectively to eliminate biases and prejudices wherever and whenever they are found to exist.

Whether the situation concerns employment practices or the providing of benefits or services no policy or procedure will be adopted or implemented which discriminates against an individual's protected class status on the basis of race, religion, color, sex, age, handicap, ancestry, national origin, or political affiliation. Diligent efforts will be made to achieve a workforce that emulates those protected classes within that population which is adjacent to the respective SRS section, division, area office or institution. Our employees must be free from negative discriminatory biases and prejudices that may impair the quality of services rendered.

The Department of Social and Rehabilitation Services is committed to an affirmative action policy which includes an assurance that no discrimination will be tolerated, particularly, against those in protected classes, in the offering of services or benefits or in employment situations which include but are not limited to hiring, promotion, training, transfer, layoff, compensation, physical facilities, or termination.

To assure equal employment opportunity within this department I offer my personal and professional commitment to non-discrimination. I have and will continue to affirm during contacts and meetings, our commitment to the tenets of affirmative action and equal employment opportunity in compliance with the legal mandates. Moreover, I demand the commitment of every employee of this Department, consistent with my expressed policy, to seek the elimination of inequality of opportunity in employment or the providing of services.

In implementing equal opportunity in employment and the offering of services or benefits within this department, I have delegated the authority necessary for the successful development and maintenance of a comprehensive and effective equal opportunity program, to the Equal Employment Opportunity Officer of this department.

All employees of the Department of Social and Rehabilitation Services will cooperate fully with the Equal Employment Opportunity Officer in the execution and maintenance of this Department's Affirmative Action Plan.

The Equal Employment Opportunity Officer is authorized to examine, review and analyze any and all records, documents, policies, and practices that may have any bearing on the successful execution of those duties and submit recommendations for corrective action.

Robert C. Harder

Secretary, State Department of
Social and Rehabilitation Services

PART II*

SRS EEO OFFICER

The SRS EEO Officer shall:

1) Administer the EEO program of this department under the supervision of the Chief of Staff Operations and the Director of Personnel Management, or as prescribed by the Secretary of the Department pursuant to existing federal, state and local laws and regulations which prohibit discrimination on the basis of race, religion, color, sex, national origin, ancestry, handicap, age, or political affiliation;

2) develop and maintain a written Affirmative Action Plan which includes a policy statement signed by the Secretary of the Department which will be made available to all persons;

3) coordinate EEO related activities for each section, division, area office and institution by providing formal training, technical assistance, instruction and aid for setting goals in recruitment, disseminating information concerning career employment opportunities, counseling aggrieved persons and handling complaints related to EEO issues;

4) establish and maintain an efficient reporting system including but not limited to collecting, analyzing and auditing employment data, indentification of problem areas, setting goals, timetables, and developing procedures for achieving those goals which will include remedies for eliminating any discriminatory practices discovered within SRS;

5) may be present while employment interviews are being conducted and participate in such interviews as requested, otherwise the EEO Officer shall make no inquiries, either written or oral, during said interview, but shall be at liberty to review procedures and discuss the substance of the interview with the interviewer(s). The substance of interviews shall be maintained in a confidential manner;

6) review any document, record and other informational resource providing that such document, record, and information resource shall be the legal property of this agency or the property of the State of Kansas currently in the custody or care of an employee of this department or other legally accessible properties except where review of the same is prohibited by law;

7) investigate any problem, situation, or practice related to EEO within this department and communicate to appropriate officials in each section,

*NOTE: Hereinafter, please refer to Appendix E for definition of terms used throughout this Affirmative Action Plan.

division, area office, and institution all innovations, laws, directives and policies which warrant alteration or correction;

8) conduct interviews with any employee of this department or recipient of services or benefits from this department as related to equal opportunity situations or practices involving employment or providing services or benefits;

9) initiate appropriate measures as deemed necessary to assure that the mandates set forth by this plan are properly observed and complied with, except that no measure herein authorized or employed shall be contrary to the law;

10) conduct and supervise on-site visits to sections, divisions, area offices and institutions for the purpose of monitoring the implementation of the affirmative action plan;

11) develop and maintain a comprehensive contract compliance program to assure that all contractors, subcontractors, suppliers, vendors and grantees doing business with SRS maintain acceptable procedures in compliance with civil rights statutes and regulations;

12) attend conferences, seminars, forums, workshops and other training programs to enhance knowledge and proficiency in the area of equal employment opportunity and affirmative action;

13) address and confer with groups regarding the EEO policies of this Department such as minority and women's organizations, religious groups, handicapped persons groups, social, fraternal and civic organizations, educational groups and federal, state, and local government officials and agencies;

14) report quarterly to the Secretary and immediate supervisors on the EEO status of the Department;

15) keep the Director of the Personnel Management Section informed on substantive matters relative to the SRS EEO program and have direct input into the Executive Committee and to the Secretary.

16) provide orientation and in-service training for EEO representatives.

CRITERIA FOR SELECTION OF DESIGNATED EEO REPRESENTATIVES:

a) An office or institution administrator will determine how many EEO representatives and alternate EEO representatives are needed to handle the EEO matters for each respective office or institution.

b) The administrator will recruit employees to serve voluntarily as EEO representatives,

c) EEO representatives should have an interest, concern, and general knowledge of EEO matters,

d) EEO representatives must be willing to follow the guidelines set forth by the Secretary under the program supervision of the EEO Officer and their respective Administrator.

e) EEO representatives will be responsible for keeping the appropriate administrator informed of complaints of discrimination.

f) EEO representatives will counsel and advise local employees regarding SRS affirmative action requirements, laws, rules and regulations.

g) EEO representatives shall protect the confidentiality of all parties involved in complaint situations.

h) EEO representatives may be given special assignments relating to civil rights matters which will be coordinated with the appropriate administrator.

i) EEO representatives may be relieved of their EEO assignment upon written notification from their administrator and/or the EEO officer for conflicts between job duties and EEO responsibilities, inefficiency, dereliction of duty, misuse or abuse of authority or other just and sufficient reason.

j) EEO representatives may resign at any time by notifying in writing the administrator and the SRS EEO officer.

PART III

Purpose of the SRS Affirmative Action Plan

PURPOSE: The principal purpose of this affirmative action plan is to afford equal opportunity to individuals seeking employment with this Department, to those persons currently employed by this Department, and to those seeking services and benefits without regard to their protected class status on the basis of race, religion, color, sex, national origin, ancestry, age, handicap or political affiliation. This comprehensive affirmative action plan is applicable to every section, office, division, area office and institution of this Department.

DISTRIBUTION AND ACCESSIBILITY TO THE SRS AFFIRMATIVE ACTION PLAN: At the direction of the Secretary of the Department copies of the SRS Affirmative Action Plan shall be distributed to each section, division, area office and institution.

A copy of the SRS Affirmative Action Plan will be accessible to each employee.

AMENDING, RESCINDING, DELETION OR SUSPENSION: The EEO Officer will amend, rescind, suspend or delete this plan or any part(s) with approval of the Secretary of the Department.

1) Any person or group of persons may request alteration in the plan by stating in writing the specific alteration(s) desired and reason(s) for such desired alteration(s).

2) All alteration requests shall be forwarded to the EEO Officer.

3) The EEO Officer shall afford a written response to each legitimate alteration request within thirty (30) days following receipt of the same.

REVISION: This plan shall be subject to periodic revision by the most expedient and practical means available and shall be accomplished under the direction of the EEO Officer or by any person or group of persons designated by him or her to act in his or her behalf.

This plan supersedes State Dir. L-852, 7-27-72, and Director of Institutions' letter dated 8-28-72, RE: Equal Employment Opportunity.

SUPPLEMENTAL PLANS: While this plan is designed to be comprehensive and all encompassing, it cannot serve to remedy all of the EEO related circumstances

encountered by any one of the subordinate units. In recognition of the preceding, compensatory measures may be required of particular subordinate units related to their respective operations. That this end might be realized the following provisions shall apply:

1) Any or all of the subordinate units are hereby granted the option of either possessing or not possessing a supplemental affirmative action plan.

2) The decision to have or not to have a supplemental affirmative action plan shall be made by the highest authority of the unit. In most instances the decision shall be that of a director or superintendent.

3) Any unit possessing a supplemental affirmative action plan shall comply with the mandates of this plan and shall not regard their supplemental plan as a substitute, wholly or in part, for the SRS plan.

4) Where substantive conflicts exist between any part or parts of the SRS affirmative action plan and any part or parts of a subordinate unit's supplemental plan, the SRS plan shall take precedent thereby rendering the conflicting part or parts of the subordinate unit's supplemental affirmative action plan null and void.

5) A copy of each subordinate unit's supplemental plan shall be submitted to the SRS EEO Officer for approval. Once a supplemental affirmative action plan is approved it automatically becomes a part of the SRS Affirmative Action Plan.

RECRUITMENT: The task of recruitment is not limited solely to attracting applicants in protected classes to particular job openings but is much broader in scope. It includes this Department's effort to demonstrate to the public our equal opportunity employer posture and our commitment to an effective affirmative action effort. As an Equal Employment Opportunity employer, this Department does not discriminate against any applicant or employee because of race, religion, color, sex, age, handicap, ancestry, national origin, or political affiliation. The utilization of any recruitment resource is predicated upon full compliance with our equal employment opportunity policy. Those responsible for recruitment include but are not limited to administrators, supervisors, the SRS EEO officer, EEO representatives, and protected class employees.

We must, in our recruiting efforts:

1) Widely distribute and publicize this Affirmative Action Plan and this Department's commitment hereto.

2) Utilize any and all appropriate publications, including but not limited to employee newsletters and periodical reports which include references to and pictures of minority employees in positions of responsibility and authority within SRS.

3) Make periodic general written reiterations of our equal employment opportunity status and our commitment to eradicate inequities in all aspects of employment within this Department,

4) Assure that all recruitment and kindred advertisements, regardless of the type of media used to convey the same, shall contain the following: "An Equal Opportunity Employer,"

5) Shall publicize and otherwise make known, to persons in protected classes not fairly represented in the Department's work force, information concerning Civil Service Exams and other preparatory mechanisms whereby upward mobility by employees might be realized.

PART IV

EEO/Affirmative Action Training

TRAINING: Each employee of this Department will be afforded training opportunities (which may include in-service or continuing education) consistent with the fiscal capabilities of this Department. Training will be available to SRS employees without regard to race, religion, color, sex, age, handicap, national origin, ancestry or political affiliation.

The responsibility for any EEO training component will be shared between the staff developing such training programs (which includes the SRS Staff Development Section and institutional trainers) and the SRS EEO officer. EEO training is available to all SRS offices and institutions for administrators and supervisors as well as other staff. The focus of EEO training will be directed toward disseminating EEO information and advice concerning Department policies and practices regarding methods for preventing and combating the adverse effects of discrimination as mandated by applicable civil rights laws and regulations. The content of EEO training will include emphasis on the Department's non-discrimination policy as it concerns members of protected classes in employment situations or in providing services or benefits in SRS programs.

SRS EEO training will include those protected classes and such situations as set forth in Part V, paragraphs 1 - 5 of this affirmative action plan. EEO training is identified according to the following categories:

1) Formal EEO training will be set out in a training kit as required under Staff Develpment Section form 702. The training kit will set forth behavioral objectives--knowledge, attitudes and skill components--key teaching points which will include content, methods and evaluations. Formal EEO training procedures will be followed in accordance with Secretary's Letter 176 in conjunction with a staff consultant assigned by the Staff Development Section to assist in whatever way needed.

2) Informal training may include consultation, technical assistance, information and clarification regarding Equal Opportunity or Affirmative Action matters. Such informal training in SRS offices will be documented in the following manner in order to fulfill the minimum requirements for federal reimbursement as training:

a) place and date

b) purpose of meeting

c) outline of content discussed

d) completion of SD 104 - Registration form

e) completion of Staff Development Evaluation form 333 and 205 or a form similar to form 205

All documentation from informal EEO training conducted in SRS offices which meet the minimum requirements for federal reimbursement will be forwarded to the SRS Staff Development Section within two weeks after training.

3) An EEO speech or presentation requested as a part of an agenda sponsored by an SRS office, group or conference involving SRS staff or provider group should be documented and sent to the Director of the Personnel Mnagement Section and the Staff Development Section. Such documentation should include the following:

a) date and place

b) target group or name of group

c) topic and outline of content

d) number of individuals in attendance

Upon request to the EEO Officer, special EEO training programs will be developed and made available to all SRS offices and institutions for supervisors and other staff by providing advice and information regarding those practices and policies which combat the adverse effects of discrimination.

PART V

Compliance

COMPLIANCE: The Secretary has directed all Department administrators to inform their employees of the criteria, requirements and responsibilities that must be followed in order to comply with the Affirmative Action Plan of the Department.

No employee in this Department shall make verbal promises assuring either: (a) appointments, (b) promotions, (c) salary increases, (d) preferential treatment, (e) immunity from reprimand or (f) any other unsanctioned favors, compensations, or benefits which are related to employment or providing services or benefits.

The unjustifiable non-adherence by a superior shall constitute grounds for complaint or grievance by the aggrieved individual(s).

Discrimination is prohibited against any member of a protected class in employment situations which include recruitment, hiring, placement, promotion, transfer, training and/or apprenticeship, compensation, layoff, termination, physical facilities, and in the offering of services and benefits to clients or patients on the basis of race, religion, color, sex, national origin, ancestry, age, handicap or political affiliation.

1) The racial or ethnic identity of an employee is to be determined by the employee. Any inquiry which would indicate an applicant's race, color, or ethnic background is prohibited. Such questions have a disparate effect upon minorities. (For a detailed explanation and description of the racial/ethnic codes used in conjuction with the SRS Affirmative Action Plan, refer to Appendix B.)

a) No qualified person shall be denied or discouraged from obtaining a job, promotion, or any employment related benefits solely or in part because of their race, color, national origin, ancestry or ethnic background.

b) No person shall be denied services or benefits because of their race, color, national origin, ancestry or ethnic gackground.

2) It is unlawful to inquire about an applicant's age or date of birth. This information is required after employment is accepted by the applicant and shall not be requested until that time. However, during the pre-employment interview statements may be made advising applicants of applicable regulations for those job classifications wherein age parameters have been otherwise established.

a) No qualified person shall be denied or discouraged from accepting employment or being offered a promotion solely or in part because of their age. NOTE: The limit and scope of this provision shall be contingent on applicable laws.

3) Any inquiry of an applicant which is not related to the job regarding an applicant's religious denomination, affiliation, church parish, pastor, religious holidays observed, or a lack there of is strictly prohibited.

4) Inquiry into any of the following areas may have the effect of discrimination because of sex: maiden name, marital status, Mr., Miss, or Mrs., prior married name, spouse's name or work, sex, or whether widowed, divorced, or separated.

a) No female employee shall be denied access to a job and/or promotion--the same of which has been traditionally reserved for male employees--if she is qualified to perform the job, or if other work related factors warrant her promotion.

b) No qualified female shall be denied access to a job due solely or in part to her marital status.

c) No female employee shall be barred from or otherwise discouraged from accepting a job or a promotion for which she is qualified solely or in part because she is pregnant.

NOTE: The limit and scope of this provision shall be contingent on applicable laws.

5) For the purpose of this plan, a handicapped person is defined as "any person who (A) has a physical or mental impairment which substantially limits one or more of such person's major life activities, (B) has a record of such an impairment, or (C) is regarded as having such an impairment."

a) No qualified handicapped person shall be barred from or otherwise discouraged from accepting a job or promotion solely or in part because of his/her handicap.

b) No person shall be denied services, benefits, education or aid because of his/her handicap.

c) No person shall be denied access to SRS facilities or programs. The accessibility to SRS facilities and programs shall be accomplished pursuant to Section 504 Subpart C of the 1973 Rehabilitation Act and other applicable statutory mandates.

6) No employee assigned to a position within SRS requiring travel shall be denied or discouraged from performing this work related function either solely or in part because of his/her race, religion, color, sex, national origin, ancestry, age, handicap or political affiliation.

For additonal information contact your immediate supervisor, your local EEO representative or the Department EEO officer located in the Central Office.

CONTRACT COMPLIANCE: SRS will not do business with any vendor or contractor whose current business practices are discriminatory on the basis of race, religion, color, sex, national origin, ancestry, age, handicap or political affiliation. Further, any vendor or contractor doing business with any SRS section, office, division or institution agrees to comply with all civil rights regulations and laws, as amended, including but not limited to the Kansas Act Against Discrimination, 1964 Civil Rights Act, 1973 Rehabilitation Act - Sections 503 and 504, and the 1967 Age Discrimination Act.

Union officials will be informed of the Department's Affirmative Action policy and any memorandum of agreement shall include a non-discrimination clause.

1) Those doing business with the Department will take affirmative action to insure that no client shall be excluded from services, benefits, aid, care or participation whereby the client would be subjected to discrimination; and that discrimination does not occur to applicants or employees in any of the following situations: hiring, employment, promotion, upgrading, placement, demotion, transfer, recruitment or recruitment advertising, lay off or termination, rates of pay or other forms of compensation, physical facilities, and selection for training including apprenticeship.

2) Those doing business with this Department shall agree that all necessary posters will be posted as required and reports will be submitted in a timely manner as set forth in the appropriate laws and regulations.

3) An affirmative action - non-discrimination clause or section is to be included and made a part of all contracts entered into between this Department and those doing business with this Department.

4) In the event of noncompliance with the Affirmative Action Clause of a contract or with any of the laws, rules, regulations, or orders, a contract may be cancelled, terminated, or suspended, in whole or part, and that person or organization doing business with the Department may be declared ineligible for further Government contracts in accordance with procedures authorized pursuant to legal mandates--particularly such sanctions as may be imposed and remedies invoked as provided in Executive Order No. 11246 and 11375, or by rule, regulation or order of the Secretary of Labor, or as otherwise provided by law.

5) If the contract authorizes subcontracting, the person or organization doing business with the Department must include affirmative action - non-discrimination provisions in every subcontract or purchase order that will be binding upon each subcontractor or vendor and will take such action with respect to any subcontract or purchase order as may be necessary as a means of enforcing such provisions, including sanctions for noncompliance. However, in the event the person or organization doing business with the Department becomes involved in, or is threatened with, litigation with a subcontractor or vendor as a result of such direction by the Department, said person or organization may request the Department to enter into such litigation to protect the interest of the Department.

COMPLIANCE AUTHORITY: Authority to sufficiently and effectively direct implementation of this comprehensive affirmative action plan is vested in the SRS EEO Officer in conjunction and coordination with those SRS sections, divisions, area offices, and institutions as required.

PART VI

COMPLAINT PROCEDURES

The Department of Social and Rehabilitation Services prohibits discrimination against any employee, applicant for employment, or client for services or other benefits because of race, religion, color, sex, age, handicap, national origin, ancestry, or political affiliation. The Department will take affirmative action to ensure that applicants are employed, and that employees are treated during employment, without discrimination because of their race, religion, color, sex, age, handicap, national origin, ancestry or political affiliation in hiring, employment, promotion, upgrading, placement, demotion, transfer, recruitment or recruitment advertising, layoff or termination, rates of pay or other forms of compensation, physical facilities, and selection for training including apprenticeship.

Any person who believes that he or she has been discriminated against by any employee, policy or procedure of this Department may seek redress by filing a formal complaint, in writing, with the local EEO representative or the Equal Employment Opportunity Officer, Department of Social and Rehabilitation Services, 6th Floor, State Office Building, Topeka, Kansas 66612. All such complaints must:

1) Be signed and dated by the person alleging discrimination
2) contain the name of the alleged discriminator, and
3) state all facts known to the complainant having bearing on the alleged act or acts of discrimination.

COMPLAINTS: All complaints alleging discrimination will be acknowledged at the earliest possible date following receipt of the same by the EEO officer or a designated EEO representative. The EEO officer may personally conduct any complaint investigation or may direct one or more EEO representatives to conduct such investigations and submit all findings in writing and in a form and manner prescribed by the EEO officer. The EEO officer and the EEO representatives shall not be impeded in the investigation of any legitimate complaint alleging discrimination.

If, during the initial interview, it is established that the complaint centers on those types of problems falling within the parameters of EEO or affirmative action, the aggrieved individual must be advised that redress may be afforded

by filing a complaint with the local EEO representative or the department EEO officer and any one or more of the following:

1) Complaint of Discrimination with the Kansas Commission on Civil Rights.*
2) Charge of Discrimination with the U. S. Equal Employment Opportunity Commission.*
3) Charge or complaint of discrimination with the local Human Relations Commission.

*NOTE: Refer to Appendix C for the address.

REGULATING COMPLAINT PROCEDURES: The EEO officer shall establish and distribute specific guidelines and rules regulating complaint procedures, including the function of EEO representatives in this area.

IMMUNITIES IN EEO MATTERS: All SRS employees involved in EEO matters shall be protected against acts of an intimidating or retaliatory nature when such involvement is related to the filing of a complaint or assisting the EEO representative or department EEO officer in the course of their official duties.

If it is believed that intimidating or retaliatory conditions exist, a written statement outlining the areas should be immediately submitted to the EEO officer. The matter will be investigated and reported to the Secretary or the Secretary's designee for final disposition.

PART VII

EEO REPORTING PROCEDURES

EEO reports or information requested shall be directed to the EEO officer on a timely and accurate basis. All reports shall be submitted on forms and in such manners as prescribed by the EEO officer. The acceptance of unsolicited reports by the EEO officer shall not relieve the reporting unit(s) of responsibilities for those reports solicited by the EEO officer.

REPORT PROCEDURES:

1) Comprehensive EEO reports will be prepared in compliance with legal mandates on behalf of the Department for identifying employees according to their respective protected class(es) and job categories.

2) The data will be analyzed to determine areas of underutilization and concentrations within the SRS workforce according to their protected classes and job classifications.

3) Data will be developed and maintained pertaining to career ladders within the job classifications of the Department.

4) Records will be developed and maintained and reports prepared according to the following informational resources

a) interviews - hiring information/applicant flow data;

b) promotions, demotions and transfers of employees;

c) training opportunities made available;

d) terminations of persons and exit interviews due to EEO related circumstances.

5) The EEO officer will prepare other reports pursuant to prevailing requirements.

UNDERUTILIZATION OF EMPLOYEES: Every effort shall be made to utilize the special talents, interests, and skills of employees. Underutilization of available skills and talents evidences, among other things, poor management, the stifling of creativity and wasted time, money and other resources.

1) Consistent with the above provision, efforts should be put forth by supervisors to seek out special and extraordinary skills and talents possessed by their subordinates.

2) Employees shall be encouraged to fully develop and use their special talents and skills in work related endeavors.

3) Employees possessing special skills and talents should be urged to accept positions wherein those skills and talents may be fully realized and wisely utilized.

4) Employees shall be encouraged to take advantage of educational opportunities offered by the department in conjunction with the establishment of departmental career opportunities.

PART VIII

GOALS AND TIME TABLES: A "goal," as herein used, shall mean a realistic objective which this department and its subordinate units endeavors to achieve on a timely basis, within the context of the merit system of employment, with special emphasis on employing remedial measures to circumvent the adverse effects of discrimination and while providing meaningful employment opportunities to all individuals without regard to race, religion, color, sex, age, handicap, national origin, ancestry or political affiliation.

A "time table" shall mean, as herein used, a pre-established date marking the anticipated realization of a recognized goal.

The only distinction worthy of note in this context between a "goal" and a "quota" is that the former results from voluntary and internal imposition to correct certain deficiencies within an organization; the latter results from the dictates of external authorities -- usually a court of law.
NOTE: Nowhere in this plan can be found a quota.

GOALS	DATE GOAL SET	TARGET DATE SET	DATA GOAL REACHED	COMMENTS
1. To develop a written Affirmative Action Plan, comprehensive in scope and sufficient to meet the diverse and growing needs of all segments of this agency.	8-1-74	12-31-74	1-1-75	The SRS Affirmative Action Plan was made available to all employees of the Department.
2. To perform on-site situation assessment and problem analysis of the eleven (11) institutions within the jurisdiction of this Department.	8-19-74	11-30-74	12-12-74	
3. To have a Clerk-Typist II position permanently assigned to the Department's EEO Officer.	8-2-74	4-30-75	1-1-77	
4. To accomplish selection of EEO Representatives consistent with the mandates set forth in this plan.	11-30-74	2-1-75	5-20-75	
5. To receive, assemble and condense data and reports furnished by the Department of Administration and Research Statistics of the type required to complete the EEO-4 Reports.	7-17-74	1-31-75	2-18-76	
6. To submit copies of this comprehensive affirmative action plan to subordinate units for implementation.	8-1-74	12-31-74	January of 1975	
7. To design and conduct training sessions for EEO Representatives and other interested personnel. Sessions to be conducted within each of the six (6) Regions.	8-26-74	3-1-75	9-15-75	

GOALS	DATE GOAL SET	TARGET DATE SET	DATE GOAL REACHED	COMMENTS
8. To review all personnel practices, directives, manuals and policies in an attempt to detect and rectify any part(s) thereof which tend(s) to promote or provide a basis for discrimination due to race, sex, age, religion, handicap, color, or national origin.	9-2-74	2-15-75	1-1-75	
9. To establish a system whereby a copy of each letter of resignation relative to any position within this Department is received by the EEO Officer. The primary objective of maintaining such a system is to try to reduce the employee turnover rate within the Department. Efforts will be made to dissuade those employees from resigning who have demonstrated that they are a definite asset to the Department or who have otherwise rendered exceptionally fine service to the Department.	10-4-74	4-15-75	9-15-75	This goal was accomplished through the training of EEO representatives to enable them to counsel with any employee contemplating resignation for EEO related reasons. Due to the structure of the Department, notification of intended resignations usually is not received until the termination papers are sent to the Personnel Management Section. Therefore, a procedure has been established department-wide whereby the EEO representatives or the EEO officer may be contacted by any employee contemplating resignation for EEO related reasons in an effort to resolve his/her problems.
10. To develop, implement, and maintain a Contract Compliance Program consistent with the mandates and guidelines set forth by Executive Order 11246, as amended. The Department's EEO Officer shall administer the program.	11-15-74	7-1-76		As of July 1, 1976, all contracts covered by federal regulations contain a nondiscrimination clause.
Goal Revision: July 1, 1977 A comprehensive procedure is being implemented to expand the contract compliance program to include Section 504 of the 1973 Rehabilitation Act as well as required reports and furnishing the data as mandated by applicable state and federal laws and regulations.		Revised Date Set 7-1-79		
11. A uniform system will be developed whereby the minority and female employees can be surveyed by job classification and by department, section, division, institution, or area.	4-1-76	11-15-76	1-1-77	

GOALS	DATE GOAL SET	TARGET DATE SET	DATE GOAL REACHED	COMMENTS
This will enable the EEO Officer to better identify areas of underutilization, determine the extent of same, and initiate measures to eliminate such underutilization(s).				
12. Develop a follow-up reporting procedure to document efforts made to remedy areas of underutilization which have been identified through the Employee Analysis by Job Category and Classification form.	7-1-76	7-1-77	1-1-78	An Applicant Flow Analysis was first prepared and submitted to the Secretary based on the workforce analysis for the quarter ending September 17, 1977. Similar reports are being prepared on a quarterly basis.
13. Establish a consistent procedure for comparing the minority and female employee representation in the SRS workforce with those minorities and females available in the labor force according to the following variables:	8-1-76	7-1-77		
(a) A comparsions between the SRS workforce and the SMSA labor force population for minorities and females (as defined by the Kansas Department of Labor. Such comparisons will be confined to the particular SRS office, institution, or other facility being surveyed.)			(a) 1-12-77	(a) A report has been prepared on the analysis of population in each SRS area and the county in which each institution is located and their surrounding counties for comparison with the workforce report to identify areas of underutilization or concentration.
(b) On-going recruitment efforts will be implemented through non-traditional sources in the local community in an attempt to exhaust any reasonable resource for recruiting qualified minorities and females for filling positions in job categories wherein an underutilization has been recognized.			(b) 4-1-77	(b) EEO representatives were trained to aid administrators in identifying and utilizing non-traditional recruitment sources.
(c) The EEO officer will contact the respective directors and superintendents when underutilizations are identified and request that they support intra-agency efforts toward eliminating such disparity through non-competive promotions of qualified minority and/or female employees.		Revised Date Set 7-1-79		

GOALS	DATE GOAL SET	TARGET DATE SET	DATE GOAL REACHED	COMMENTS
14. Develop and implement an on-going system for an office or institution which will offer greater opportunities of upward mobility for those concentrated areas of minorities and females in the current workforce. Efforts will be directed at determining the aspirations, education, and skills of minority and female employees.	7-15-76	4-15-77		This goal was reached in part. See Secretary's Letter 182 dated September 13, 1977 regarding Announcing and Filling Vacant Positions.
Goal Revision: July 1, 1977 In conjunction with the establishment of this goal, career ladders will be established within each subordinate unit of the Department.		Revised Date Set 7-1-79		
15. Revise the Affirmative Action Plan for the Department of Social and Rehabilitation Services to include any changes in administrative procedures and new legislation.	7-12-76	2-15-77	6-1-78	
Goal Revision: September 15, 1977. Redesign the affirmative action plan to accommodate annual review with subsequent revisions as required.		Revised Date Set To be reviewed annually and revised when necessary		
16. Develop and maintain a reporting system for each office, section, institution, and division reflecting their workforce by age and physical handicap in conjunction with each EEO job category.	9-1-77	7-1-79		
17. Establish EEO Technician position to be assigned to The Department EEO Officer.	7-1-77	7-1-79		
18. Reclassify the Clerk Typist II position to a Secretary I position to be assigned to the Department EEO Officer.	4-1-77	7-1-78		

GOALS	DATE GOAL SET	TARGET DATE SET	DATE GOAL REACHED	COMMENTS
19. Develop a monitoring procedure to assure that position descriptions are reviewed and revised on no less than a biennial basis to assure that the job requirements are non-discriminatory.	9-1-77	1-1-79		
20. Develop and maintain a list of recruitment resources being used by each section, office, institution or division within the Department.	9-1-77	7-1-78		
21. Review and revise the employment vacancy announcement procedure to be correlated more closely with career ladders established within respective offices, institutions, sections or divisions.	3-1-78	7-1-79		
22. Develop a comprehensive SRS EEO Poster to be used in lieu of the State Poster.	10-1-77	10-1-78	5-1-78	Posters to be initially distributed with Affirmative Action Plan as revised 6-1-78.
23. Develop, implement and maintain a system whereby the SRS workforce may be surveyed according to age.	5-1-78	7-1-79		
24. Develop, implement and maintain a system whereby the SRS workforce may be surveyed according to handicap.	5-1-78	7-1-79		
25. Review, develop, and/or revise all EEO forms for the purpose of including data regarding the handicapped in conjunction with Section 504 of the 1973 Rehabilitation Act.	7-1-78	7-1-80		

APPENDICES

APPENDIX A

SUPPORTIVE DATA AND RECORD RETENTION REQUIREMENTS
FOR AFFIRMATIVE ACTION PLAN

1. Copies of all EEO reports shall be retained for a minimum of three full years.

2. Information on recruitment efforts such as advertisements or correspondence shall be retained for a minimum of three full years.

3. A chronological list of all applicants and new hires will be retained on Table I; a record of all job related training will be maintained on Table II; a record of all promotions and transfers will be recorded on Table III; a record of all terminations will be reflected on Table IV; and a comprehensive workforce analysis by race and sex will be indicated on Table VII; Tables I, II, III, IV and VII will be prepared on a quarterly basis in compliance with federal reporting requirements for the EEO-4 Reports and retained for an indefinate period.

4. Copies of any charges, data, notices, orders, or agreements reached pursuant to <u>any</u> civil rights investigations shall be indefinitely retained.

5. Copies of all Labor Agreements shall be retained for a minimum of three full years.

6. Records concerning job promotional opportunities or career ladders shall be indefinitely retained.

7. The Affirmative Action Plan shall be reviewed annually and revised whenever necessary. Goals and their attainment shall be assessed on an annual basis.

8. All job related tests used in personnel selection are to be retained for three full years. These tests are any tests given by SRS staff in addition to those given by Division of Personnel.

9. Position descriptions and qualifications for each position shall be reviewed and/or revised on an annual basis.

APPENDIX B

DETAILED EXPLANATION OF RACIAL/ETHNIC GROUP

Ethnic Code	Definition
1	White (not of Hispanic origin) - Persons having origins in any of the original peoples of Europe, North Africa, or the Middle East.
2	Black (not of Hispanic origin) - Persons having origins in any of the black racial groups of Africa.
3	Hispanic (Spanish Surnamed Americans - SSA) - Persons of Mexican, Puerto Rican, Cuban, Central or South American or other Spanish culture or origin, regardless of race.
4	American Indian or Alaskan Native - Persons having origins in the original peoples of North America and who maintain cultural identification through tribal affiliation or community recognition.
5	Asian or Pacific Islanders - Persons having origins in any of the original peoples of the Far East, Southeast Asia, the subcontinent of India, or the Pacific Islands. This area includes China, Japan, Korea, Philippine Island and Samoa.

NOTE: These definitions are prescribed by the Department of Administration Policy and Procedure Manual under Filing No. 12,800, Date Issued 7/3/72 and Revised 6/27/77.

APPENDIX C

Resource List of Agencies with Regulatory Powers or Vested Interest in Effectuating Affirmative Action and Securing Equality of Opportunity.

Posters and other information on affirmative action can be obtained from but not limited to the following list of sources:

STATE RESOURCES:

1. Kansas Commission on Civil Rights (K.C.C.R.)
   535 Kansas Avenue - 5th Floor
   Topeka, Kansas 66603
   (913) 296-3206 - KANS-A-N 561-3206
   (Posters, pamphlets, films and technical assistance available upon request.)

2. Kansas Department of Human Resources
   Public Employees Relations Board
   535 Kansas Avenue
   Topeka, Kansas 66603
   (913) 296-3094 - KANS-A-N 561-3094

   Division of Employment
   401 Topeka Boulevard
   Topeka, Kansas 66603
   (913) 296-5000 - KANS-A-N 561-5000

3. Kansas Department of Administration
   Division of Personnel
   State Office Building
   Topeka, Kansas 66612
   (913) 296-4278 - KANS-A-N 561-4278

   Equal Employment Opportunity Office
   503 Kansas Avenue - Room 542
   Topeka, Kansas 66603
   (913) 296-4288 - KANS-A-N 561-4288

FEDERAL RESOURCES:

4. U.S. Equal Empolyment Opportunity Commission (E.E.O.C.)
   Kansas City District Office
   1150 Grand Avenue
   Kansas City, Missouri 64106
   (816) 374-5773
   (Request the EEOC Packet for Employers and Federal "Equal Employment Opportunity is the Law" poster.)

5. U.S. Department of Labor - Employment Standards Administration, (U.S. D.O.L.)

   Wage and Hour Division
   220 West Douglas
   Room 200 Page Court
   Wichita, Kansas 67202
   (316) 267-6311, ext. 466
   (For information concerning Age Discrimination)

Office of Federal Contract
Compliance Program - Regional Office (OFCC)
911 Walnut Street
Kansas City, Missouri 64106
(816) 374-5384
(For information concerning Executive Orders 11246 and 11375, and Section 402 of the Vietnam Era Veterans Readjustment Assistance Act of 1974)

Office of Civil Rights (U.S. D.O.L. O.C.R.)
911 Walnut Street
Kansas City, Missouri 64106
(816) 374-2695
(For information concerning Section 503 of the 1973 Rehabilitation Act regarding the Handicapped)

U.S. Department of Health, Education, and Welfare
Regional Director's Office
601 East Twelfth Street
Kansas City, Missouri 64106
(816) 374-5384
HEW Office of Civil Rights - (816) 374-2474 or (816) 374-2156
1150 Grand - 7th Floor
Kansas City, Missouri 64106

(For information concerning Section 504 of the 1973 Rehabilitation Act regarding the Handicapped)

6. U.S. Civil Service Commission (U.S.C.S.C.)
601 East Twelfth Street
Kansas City, Missouri 64106
(816) 374-5705
374-5156

7. U.S. Department of Housing and Urban Development (HUD)
Regional Office
911 Walnut Street
Kansas City, Missouri 64106
(816) 374-4391

8. U.S. Commission on Civil Rights
911 Walnut - Room 3100
Kansas City, Missouri 64106
(816) 374-2453

9. U.S. Justice Department
Regional Office
811 Grand
Kansas City, Misouri 64106
(816) 374-2631

APPENDIX D

LEGAL MANDATES AND REGULATIONS

1. Title VI of the Civil Rights Act of 1964 - NONDISCRIMINATION IN FEDERALLY ASSISTED PROGRAMS, as amended (Section 601, No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."

2. Title VII of the Civil Rights Act of 1964 (As Amended by the Equal Employment Act of 1972. This act, as amended, prohibits discrimination because of race, color, religion, sex or national origin, in any term, condition or privilege of employment. The Equal Employment Opportunity Commission is charged with the responsibility of overall enforcement of this law.

3. Executive Order 11246 (As Amended by Executive Order 11375): This order as issued by the President in 1965, requires Affirmative Action Programs by all Federal contractors and subcontractors. It requires that firms with contracts over $50,000 and 50 or more employees develop and implement written programs which are monitored by an assigned Federal compliance agency.

4. The Equal Pay Act of 1963: This act requires all employers subject to the Fair Labor Standards Act (FLSA) to provide equal pay for men and women performing similar work.

5. The Age Discrimination in Employment Act of 1967 (As Amended): This act prohibits employers from discriminating against persons 40-65 years of age in any area of employment because of age.

6. The Civil Rights Acts of 1866 and 1870 and the Equal Protection Clause of the 14th Amendments to the Constitution: Action under these laws on behalf of individuals or groups may be taken by individuals, private organizations, trade unions and other groups.

7. K.S.A. 44-1001 - 44-1927 (As Amended--The Kansas Act Against Discrimination): This act prohibits discrimination in employment, all places of public accommodation and housing.
   A. Cit. (K.S.A. 44-1001): "It is also declared to be policy to assure equal opportunities and encouragement to every citizen regardless of race, religion, color, sex, physical handicap, national origin or ancestry, in securing and holding, without discrimination, employment in any field of work or labor for which he is properly qualified. . ."

   B. Cit. (K.S.A. 44-1009, 7, (b)): "It shall not be an unlawful employment practice to fill vacancies in such a way as to eliminate or reduce imbalance with respect to race, color, sex, physical handicap, national origin or ancestry."

C. Cit. (K.S.A. 44-1009, 7, (c)): "It shall be an unlawful discriminatory practice: . . . (3) For any person, as defined herein, to refuse, deny, make a distinction, directly or indirectly, or discriminate in any way against persons because of the race, religion, color, sex, physical handicap, national origin or ancestry of such persons in the full and equal use and enjoyment of the services, facilities, privileges and advantages of any institution, department or agency of the State of Kansas or any political subdivision or municipality thereof."

8. K.S.A. 44-117--Prevention of Blacklisting: This law prohibits any employer from preventing or otherwise obstructing or attempting to prevent or obstruct a former employee from obtaining employment with any other employer. (Penalty: Any person found guilty of the foregoing may be subject to a fine of $100 and 30 days imprisonment per K.S.A. 44-118).

9. K.S.A. 44-413--Employment of Handicapped Workers; This law provides a legal mandate for employing the handicapped in the State of Kansas.

10. Kansas Code of Fair Practices: The code enunciates the standards relative to ethics in employment and kindred subject matters.

11. Title 41-Public Contracts and Property Management - Part 60-1--Obligations of Contractors and Subcontractors. This regulation assures that all persons shall have an equal opportunity without regard to race, creed, color or national origin in employment with Government contractors or with contractors performing under federally assisted construction contracts.

12. Title 41 Public Contracts and Property Management - Part 60-2: This regulation covers non-construction contractors. It requires each prime contractor or sub-contractor with 50 or more employees and a contract of $50,000 or more within 120 days from commencement of a contract to develop a written affirmative action compliance program for each of its establishments, and such contractors are now further required to revise existing written affirmative action programs to include the changes embodied in Title 41.

13. Section 503 of the 1973 Rehabilitation Act.
This regulation requires that "Every employer doing business with the Federal Government under a contract for more than $2,500 must take 'affirmative action' to hire handicapped people. "affirmative action" also applies to job assignments, promotions, training, transfers, accessibility, working conditions, termination, and the like."

14. Section 504 of the 1973 Rehabilitation Act.
This regulation implements procedures which "forbids acts of discrimination against qualified persons in employment and in the operation of programs and activities receiving assistance from the Department of Health, Education, and Welfare."

15. Hatch Act as amended.
Discrimination because of political affiliation is prohibited by this regulation as applied to state and Federal employees.

NOTE: The preceding list of laws and regulations does not exhaust the applicable list of legal mandates.

APPENDIX E

DEFINITIONS OF TERMS

1. Affected Class - Those groups of minorities, females, the elderly, and the disabled who by virtue of past discrimination continue to suffer the effects of such discrimination. Affected class status must be determined by analysis or court decision.

2. Affirmative Action - Affirmative Action is the taking of a positive measure, not expressly prohibited by law, to eliminate the adverse effects of discrimination and promote or advance equality of opportunity in a manner beneficial to all persons.

   It can be any activity initiated by an employer which contributes toward the greater utilization of protected or affected classes which may include a written affirmative action plan, including goals established by units and timetables for completion.

   Specific Affirmative Action may be ordered by a court of law to remedy discriminatory practices, the effect of past discriminatory practices or as a means of assuring equality of opportunity.

3. Affirmative Action Groups - Those persons identified by the federal and state laws to be specifically protected from employment discrimination, because of race, religion, color, sex, age, handicap, national origin, ancestry, or political affiliation.

4. BFOQ or BOQ - "bona fide occupational qualification" For all practical purposes, almost all jobs must be open legally to men and women. The "bona-fide occupational qualification" (BFOQ) exception of Title VII is narrowly construed by EEOC and the courts. The burden of proof is on the employer to establish that the sexual characteristics of the employee are crucial to successful performance of the job (such as wet nurse) or that there is need for authenticity (such as a model, actor, or actress). Only when the essence of the business enterprise would be undermined by not hiring a member of one sex exclusively is a BFOQ justified. BFOQ is also narrowly interpreted under the Age Discrimination in Employment Act, but some exemptions are specified.

5. Burden of Proof - The responsibility for demonstrating to the requisite degree, the truth of one's claim; the affirmative duty of proving or disproving the claim at issue.

6. "Business Necessity" - Criteria placed on applicants that are valid and necessary for the effective conduct of the organization objectives and the particular job. The courts have consistently struck down overly stringent criteria which have been shown to have a disparate effect on affirmative action category groups.

7. Career Ladder - The jobs which require related and increasingly more responsible duties through which employees advance by experience and in-service training in the lower jobs. Career ladders should be equal in quantitative opportunity and salary range for those jobs having high affirmative action group utilization compared with those having primarily white male incumbents.

8. Civil Rights Act of 1964 as amended by the Equal Employment Opportunity Act of 1972 - Title VII - The first legislation to make it an unlawful employment practice to discriminate on the basis of race, color, religion, sex, or national origin. All other federal and state EEO legislation is patterned after or supportive of Title VII.

   The complainant in a Title VII trial must carry the initial burden under the statute of establishing a prima facie case of racial discrimination. This may be done by showing:
   1) That he/she belongs to a racial minority;
   2) That he/she applied and has qualified for a job for which the employer was seeking applicants;
   3) That, after the rejection, the position remained open and the employer continued to seek applicants from persons with qualifications similar to those of the complainant's. The burden then must shift to the employer to articulate some legitimate, non-discriminatory reason for employer's rejection of the complainant.

9. Class Actions:

   Prerequisites to a class action:

   One or more members of a class may sue or be sued as representative parties on behalf of all only if
   1) The class is so numerous that joinder of all members is impracticable,
   2) There are questions of law or fact common to the class,
   3) The claims or defenses of the representative parties are typical of the claims or defenses of the class, and,
   4) The representative parties will fairly and adequately protect the interests of the class. For the most part this rule has been applied liberally in Title VII employment discrimination cases.

10. Compliance - Compliance is the support of and adherence to established policies, laws and guidelines (as those enumerated in this Affirmative Action Plan) whose aim is the eradication of inequality and discrimination.

11. Discrimination - Discrimination is unequal and disparate treatment of a person or persons, the act and manner of which is expressly prohibited by law or the effect of such unequal or disparate treatment or the threat of the same is sufficient to render a person or persons incapable of enjoying the same degree of freedoms, privileges and immunities enjoyed by other persons in society whose rights, as they apply herein, are positively sanctioned by law.

a) Overt Discrimination - Overt Discrimination is discrimination as defined in 11., above, with intent--commit such an act without attempting to conceal any aspect of the act from the public or other persons, including the victim(s) of such discrimination.
EXAMPLE: " . . . we only hire white people."

b) Covert Discrimination - Covert Discrimination has all of the ingredients of Overt Discrimination, except that some conscious attempt is made by the discriminator to conceal the act of discrimination. The element of secrecy distinguishes Covert Discrimination from Overt Discrimination.
EXAMPLE: Why, we don't discriminate; how could we when we don't have any minorities working here. . ."

c) Systemic Discrimination - Systemic Discrimination differs from Overt and Covert Discrimination in that the culpable (blameworthy) party cannot be easily identified. Systemic Discrimination appears most frequently as the residue of a system which has formerly been plagued by both Overt and Covert Discrimination and retains the effects of past Overt - Covert Discriminatory practices and policies.
EXAMPLE: "We're just one big happy family, here. See those two old colored boys in the hall over there, they've been with us for over 28 years. Together, they keep this building shining like a new penny. Ask them if they have any racial problems. . ."

12. Disparate effect or disparate impact - the result of an employment policy, practice, or procedure that, in practical application, has less favorable consequences for an affirmative action group than for the dominant group.

13. Employment parity - when the proportion of affirmative action groups in the external labor market is equivalent to their proportion in the state work force without reference to classification.

14. Equal Employment Opportunity - Equal Employment Opportunity is the right of all persons to work and to advance on the basis of merit, ability and potential.

15. EEOC - a federal commission on Equal Employment Opportunity which has the power to bring suits, subpoena witnesses, issue guidelines which have the force of law, render decisions, provide technical assistance to employers, provide legal assistance to complainants, etc.

16. GED - General Educational Development - the GED certificate is the high school equivalency certificate which the Kansas State Department of Education recognizes as equal to the high school diploma.

17. Goals - good faith quantitative objectives which an employer voluntarily sets as the minimum progress he can make within a certain time period through his all-out efforts at outreach recruitment, validating selection criteria, creation of trainee positions, career ladders, etc. Goals and objectives are considered proper and legal responses to underutilization by EEOC, OFCC, USCSC, DOL, and the White House.

18. Hiring Standards:

a) Educational Requirements:
Where it can be shown that minority groups are less likely to possess educational qualifications required by an employer and where such qualificatons are not job related, courts will strike down the use of such criteria.

b) Tests:
Tests utilized by employers which disproportionately screen out minorities and women compared to non-minorities and males and which are not job related, are deemed unlawful by the courts.

c) Relatives Preference:
Giving preference to relatives of incumbent employees with respect to employment opportunities is unlawful if said incumbents are substantially non-minority.

19. Occupational Parity - when the proportion of affirmative action group employees in all occupational levels is equivalent to their respective availability in the external labor market. Eventually, with the goal of equal educational and training opportunities, employment parity and occupational parity will be equal.

20. Parity - the long-term goal of affirmative action which is reached when employment and occupational parity are identical.

21. Prima facie - the elements necessary to support the claim have been presented and unless evidence can be presented to rebut the previous arguments, the claim will be supported. In the EEO area, statistics of underutilization have been sufficient to make a prima facie case for discrimination, then it is the responsibility of the employer to justify those statistics through "business necessity," BFOQ's, etc.

22. Probable cause - reasonable on the basis of the evidence but not certain or proved. Before initiating court action, the federal EEOC and the Kansas Commission on Civil Rights make a determination of no cause, probable cause, or cause. In incidents of probable cause or cause, pre-trial negotiations and conciliation generally resolve the issues before the case can get into court.

23. Protected Class - legally identified groups that are specifically protected by statute against employment discrimination. Unlike "affected class" which must be demonstrated, protected class status is automatically conferred upon recognized minority group members, females, etc., by virtue of the law or other court decisions interpreting the law.

24. Quotas - fixed hiring and promotion rates based on race, sex, etc. which must be met at all costs and do not take into consideration the availability, education, or training of the external labor force or protected class members, nor the employer's internal labor situation with respect to project manpower requirements. Quotas are considered to be last resort measures available only for the courts to impose when good faith efforts do not exist.

25. Recruitment: Where a work force is all or substantially all white, reliance upon word-of-mouth dissemination of information only to the friends and relatives of present employees is unlawful. Similarly it is unlawful to give false or misleading information to minority group persons, or to fail or to refuse to inform them of work opportunities and the procedures for obtaining them.

26. SMSA - Standard Metropolitan Statistical Area - the area of employee recruitment against which parity and utilization levels are compared. The SMSA may vary depending upon level of job class, availability of applicants, location of work station, etc.

27. Timetables - consecutive time durations (generally in affirmative action, a timetable covers one year) during which the specific quantitative goals and objectives for that year are to be met and evaluations of progress are made before beginning the subsequent timetable with its own specific goals and objectives.

28. Underutilization - term used to describe a lower number of affirmative action group employees than parity would predict. Once underutilization is quantitatively established, the burden of proof rests on the employer to demonstrate that the underutilization is the legitimate effect of BFOQ and valid criteria of business necessity (also called under-representation).

29. Validity - the extent to which a test, criterion, or qualification measures the trait (some job performance ability) for which it is being used, rather than some other trait. "Business necessity" considerations are addressed to the usefulness of the test in predicting job performance and the minimum cut-off scores.

APPENDIX F

fice or
stitution Agency 628 - 629 and Mental Health and Retardation CONSOLIDATED EMPLOYEE REPORT - TABLE VII
te 3-18-78 to 6-17-78

Submit at end of each fiscal quarter to Director of Equal Employment Opportunity.

JOB CATEGORY	(1) WHITE			(2) BLACK			(3) HISPANIC-SSA			(4) AMERICAN INDIAN ALASKAN NATIVE			(5) ASIAN (ORIENTAL)			*TOTAL MINORITY EMPLOYEES			* TOTALS		
) Officials and	M	F	Tot.	M	F	Tot.	M	F	Tot.	M	F	Tot.	M	F	Tot.	M	F	TOT.	M	F	Total
Administrators	86	36	122	8	3	11	3	–	3				1	–	1	12	3	15	98	39	137
Percentage	62.8	26.3	89.1	5.8	2.2	8	2.2		2.2				.7		.7	8.7	2.2	10.9	71.5	28.5	100
																		+		–	
B) Professionals	763	1331	2094	24	70	94	21	9	30	4	3	7	9	9	18	58	91	149	821	1422	2243
Percentage	34	59.3	93.3	1.1	3.1	4.2	.9	.4	1.3	.2	.1	.3	.4	.4	.8	2.6	4.1	6.6	36.6	63.4	100
																		+		+	
C) Technicians	34	606	640	4	60	64	2	11	13	–	2	2	–	1	1	6	74	80	40	680	720
Percentage	4.7	84.2	88.9	5.6	8.3	8.9	.3	1.5	1.8		.3	.3		.14	.14	.8	10.3	11.1	5.6	94.4	100
																		–		+	
D) Protective	50	1	51	7	–	7	–	3	3							7	3	10	57	4	61
Service-Security																					
Percentage	82	1.6	83.6	11.5		11.5		4.9	4.9							11.5	4.9	16.4	93.4	6.6	100
																		+		+	
E) Paraprofessionals	490.5	1299.5	1790	154	304	458	26	31	57	2	2	4	1	2	3	183	339	522	673.5	1638.5	2312
Percentage	21.2	56.2	77.4	6.7	13.1	19.8	1.1	1.3	2.4	.09	.09	.17	.04	.09	.13	7.9	14.7	22.6	29.1	70.9	100
																		+		+	
F) Office and	80	1132	1212	3	78	81	2	25	27	–	4	4	2	5	7	7	112	119	87	1244	1331
Clerical																					
Percentage	6	85	91	.2	5.9	6.1	.15	1.9	2		.3	.3	.15	.4	.5	.5	8.4	8.9	6.5	93.5	100
																		+		–	
G) Skilled Crafts	252.5	11	263.5	6	–	6	5	–	5	3	–	3				14	–	14	266.5	11	277.5
Percentage	91	4	95	2.2		2.2	1.8		1.8	1		1				5		5	96	4	100
																		–		–	
H) Service and	241.5	347	588.5	57	99	156	8	13	21	2	2	4	–	2	2	67	116	183	308.5	463	7715
Maintenance																					
Percentage	31.3	45	76.3	7.4	12.8	20.2	1	1.7	2.7	.26	.26	.52		.26	.26	8.7	15	23.7	40	60	100
																		–		+	
TOTALS	1997.5	4763.5	6761	263	614	877	67	92	159	11	13	24	13	19	32	354	738	1092	2351.5	5501.5	7853
Percentage	25.4	60.7	86.1	3.3	7.8	11.1	.8	1.2	2	.14	.17	.31	.17	.2	.3	4.5	9.4	13.9	29.9	70.1	100
			–									+		–				+		+	

*Percentage of Gain or Loss in each job category is indicated by a + or - in the totals columns.

fice or
stitution Agency 628 - 629
te 3-18-78 to 6-17-78

CONSOLIDATED EMPLOYEE REPORT - TABLE VII

Submit at end of each fiscal quarter to Director of Equal Employment Opportunity.

JOB CATEGORY	(1) WHITE			(2) BLACK			(3) HISPANIC-SSA			(4) AMERICAN INDIAN ALASKAN NATIVE			(5) ASIAN (ORIENTAL)			* TOTAL MINORITY EMPLOYEES			* TOTALS		
.) Officials and	M	F	Tot.	M	F	Tot.	M	F	Tot.	M	F	Tot.	M	F	Tot.	M	F	TOT.	M	F	Total
Administrators	40	15	55	3	3	6	1	-	1							4	3	7	44	18	62
Percentage	64.5	24.2	88.7	4.8	4.8	9.67	1.6		1.6							6.5	4.8	11.3	71	29	100
																		+		—	
B) Professionals	548	949	1497	12	47	59	6	4	10	3	2	5	2	3	5	23	56	79	571	1005	1576
Percentage	34.8	60.2	95	.8	3	3.7	.4	.2	.6	.2	.1	.3	.1	.2	.3	1.4	3.6	5	36.2	63.8	100
																		—		+	
C) Technicians	11	522	533	1	50	51	1	8	9	-	1	1				2	59	61	13	581	594
Percentage	1.8	87.9	89.7	.17	8.4	8.6	.17	1.3	1.5		.17	.17				.34	9.9	10.3	2.2	97.8	100
																		—		+	
D) Protective Service-Security																					
Percentage																					
E) Paraprofessionals	10	28	38	5	13	18	1	3	4							6	16	22	16	44	60
Percentage	16.7	46.7	63.3	8.3	21.7	30	1.7	5	6.7							10	26.7	36.7	26.7	73.3	100
																		+		+	
F) Office and Clerical	30	770	800	2	56	58	1	18	19	-	4	4	-	2	2	3	80	83	33	850	883
Percentage	3.4	87.2	90.6	.23	6.3	6.6	.11	2.04	2.15		.45	.45		.23	.23	.34	9.06	9.4	3.7	96.3	100
																		—		—	
G) Skilled Crafts	12	5	17																12	5	17
Percentage	70.6	29.4	100																70.6	29.4	100
																				—	
H) Service and Maintenance	48	34	82	12	4	16	1	1	2	2	-	2				15	5	20	63	39	102
Percentage	47.1	33.3	80.4	11.8	3.9	15.7	.98	.98	1.96	1.96		1.96				14.7	4.9	19.6	61.8	38.2	100
																		—		+	
TOTALS	699	2323	3022	35	173	208	11	34	45	5	7	12	2	5	7	53	219	272	752	2542	3294
Percentage	21.2	70.5	91.7	1.06	5.25	6.31	.33	1.03	1.36	.15	.21	.36	.06	.15	.21	1.6	6.6	8.2	22.8	77.8	100
			+									+						—		+	

*The percentage of Gain or Loss in each job category is indicated by a + or - in the totals columns.

(a)

fice or
stitution All Institutions
te 3-18-78 to 6-17-78

CONSOLIDATED EMPLOYEE REPORT - TABLE VII

Submit at end of each fiscal quarter to Director of Equal Employment Opportunity.

JOB CATEGORY	(1) WHITE			(2) BLACK			(3) HISPANIC-SSA			(4) AMERICAN INDIAN ALASKAN NATIVE			(5) ASIAN (ORIENTAL)			*TOTAL MINORITY EMPLOYEES			*TOTALS		
) Officials and	M	F	Tot.	M	F	Tot.	M	F	Tot.	M	F	Tot.	M	F	Tot.	M	F	TOT.	M	F	Total
Administrators	46	21	67	5	–	5	2	–	2				1	–	1	8	–	8	54	21	75
Percentage	61.3	28	89.3	6.7		6.7	2.7		2.7				1.3		1.3	10.7		10.7	72	28	100
																		+			+
B) Professionals	215	382	597	12	23	35	15	5	20	1	1	2	7	6	13	35	35	70	250	417	667
Percentage	32.2	57.3	89.5	1.8	3.4	5.2	2.2	.8	3	.15	.15	.3	1	.9	1.9	5.2	5.2	10.5	37.5	62.5	100
																		–		+	
C) Technicians	23	84	107	3	10	13	1	3	4	–	1	1	–	1	1	4	15	19	27	99	126
Percentage	18.2	66.7	84.9	2.4	7.9	10.3	.8	2.4	3.2		.8	.8		.8	.8	3.2	11.9	15.1	21.4	78.6	100
																		–		–	
D) Protective	50	1	51	7	–	7	–	3	3							7	3	10	57	4	61
Service-Security																					
Percentage	82	1.6	83.6	11.5		11.5		4.9	4.9							11.5	4.9	16.4	93.4	6.6	100
																		+		+	
E) Paraprofessionals	480.5	1271.5	1752	149	291	440	25	28	53	2	2	4	1	2	3	177	323	500	657.5	1594.5	2252
Percentage	21.3	56.5	77.8	6.6	12.9	19.5	1.1	1.2	2.3	.09	.09	.18	.04	.09	.13	7.9	14.3	22.2	29.2	70.8	100
																		+		+	
F) Office and	50	362	412	1	22	23	1	7	8				2	3	5	4	32	36	54	394	448
Clerical																					
Percentage	11.2	80.8	92	.2	4.9	5.1	.2	1.6	1.8				.4	.7	1.1	.9	7.1	8	12.1	87.9	100
																		+		+	
G) Skilled Crafts	240.5	6	246.5	6	–	6	5	–	5	3	–	3				14	–	14	254.5	6	260.5
Percentage	92.3	2.3	94.6	2.3		2.3	1.9		1.9	1.15		1.15				5.4		5.4	97.7	2.3	100
																		+		+	
H) Service and	193.5	313	506.5	45	95	140	7	12	19	–	2	2	–	2	2	52	111	163	245.5	424	669.5
Maintenance																					
Percentage	28.9	46.8	75.7	6.7	14.2	20.9	1	1.8	2.8		.3	.3		.3	.3	7.7	16.6	24.3	36.7	63.3	100
																				+	
TOTALS	1298.5	2440.5	3739	228	441	669	56	58	114	6	6	12	11	14	25	301	519	820	1599.5	2959.5	4559
Percentage	28.5	53.5	82	5	9.7	14.7	1.2	1.3	2.5	.13	.13	.26	.2	.3	.5	6.6	11.4	18	35.1	64.9	100
			–			+			+									+		+	

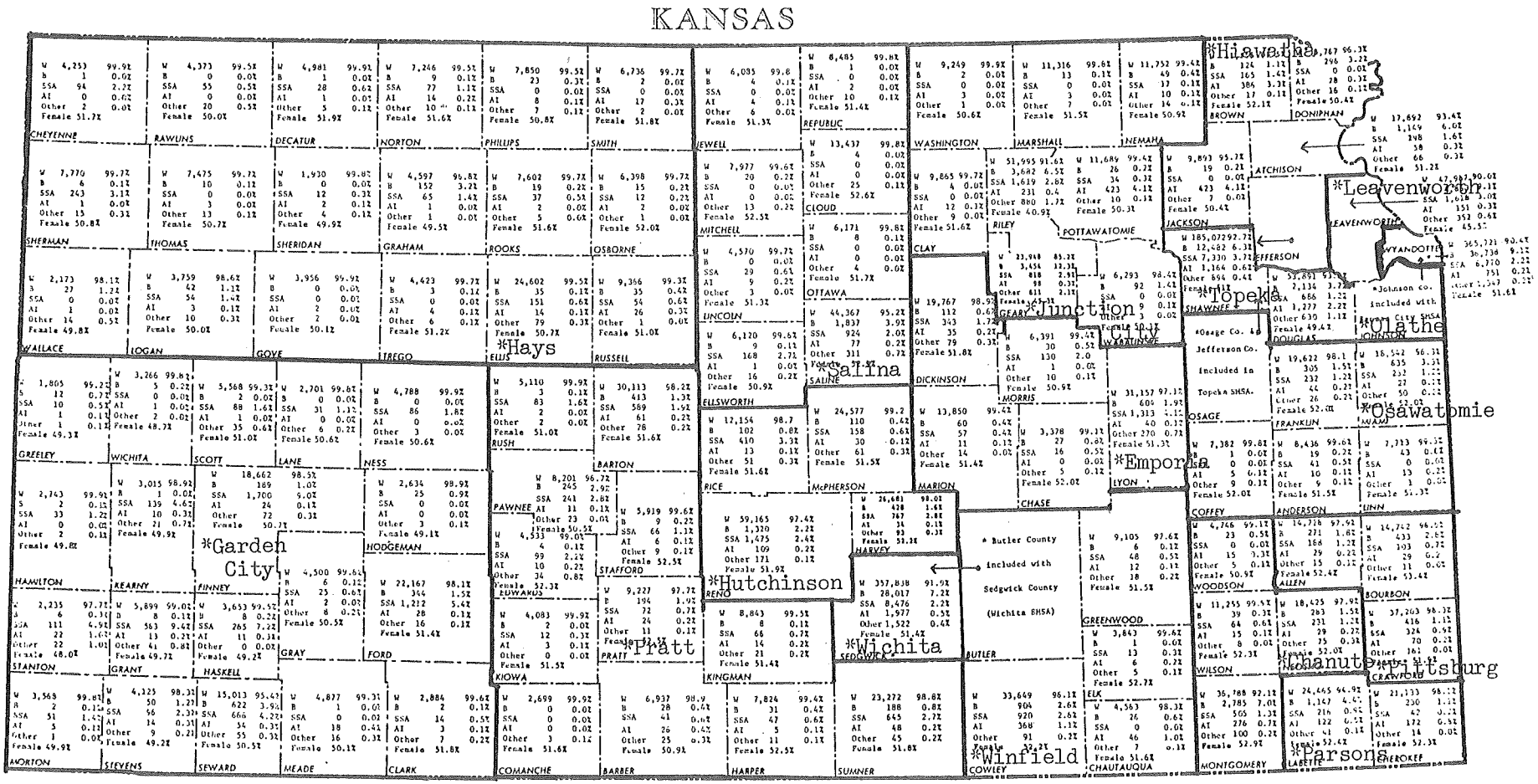
*The percentage of Gain or Loss in each job category is indicated by a + or – in the totals columns.

43 (d)

Part 2 (b)

COMPARATIVE CENSUS DATA BY RACE AND SEX FOR SRS AREA OFFICES

The workforce in any management area may be compared with the average of the figures given for each county within each management area to determine such factors as underutilizations or over-concentrations.



* Denotes SRS Area Offices. Bold lines outline each SRS management area.

(Data compiled from 1970 U. S. Census)

6/78

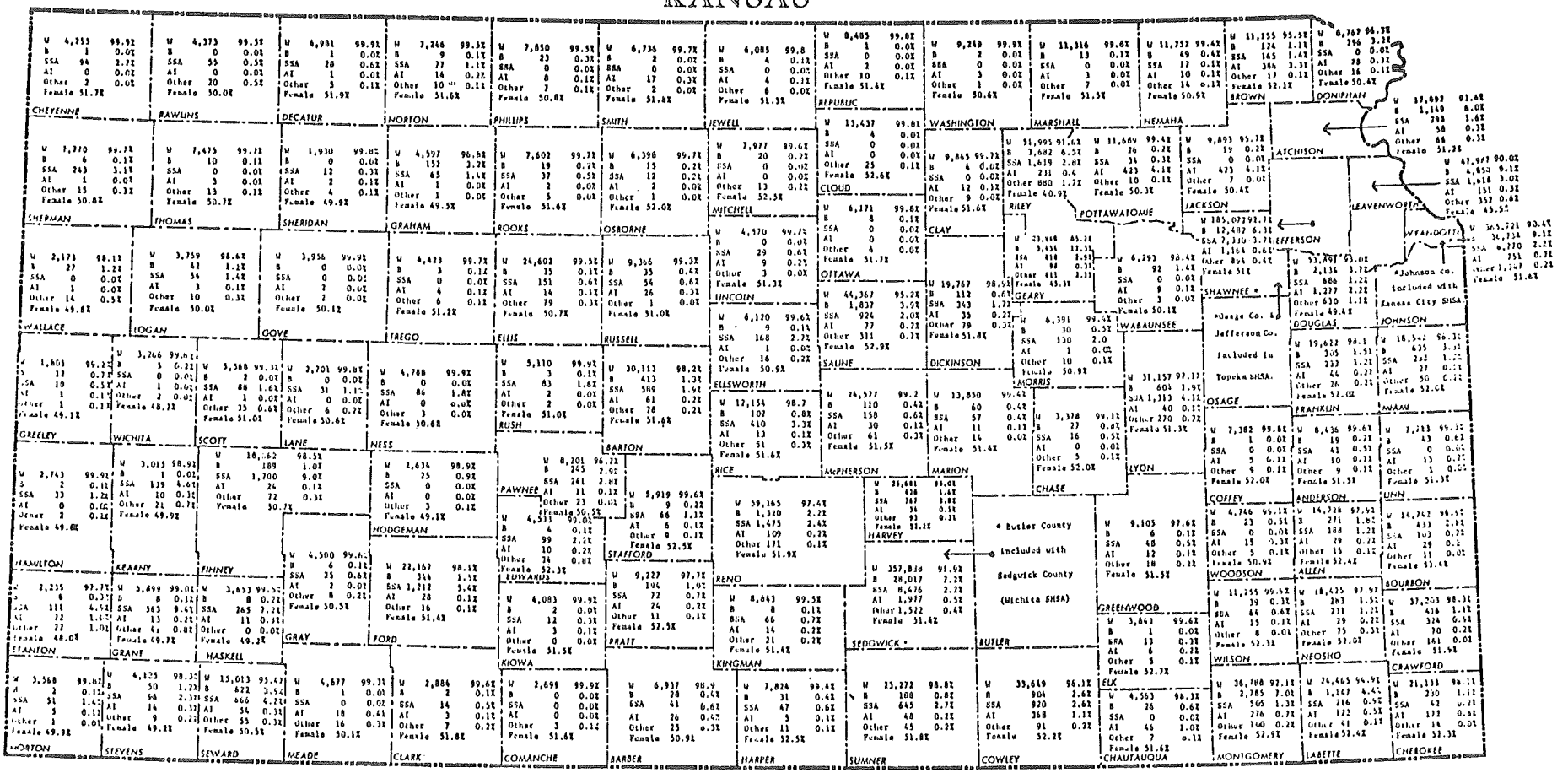
COMPARATIVE CENSUS DATA BY RACE AND SEX

Average of State ethnic population

White	92.4%
Black	4.8%
Spanish Surnamed Americans	2.1%
American Indian	.4%
Other	.3%

Average of State females (over age 14) and classified as being available in the workforce equals 51.63%

KANSAS

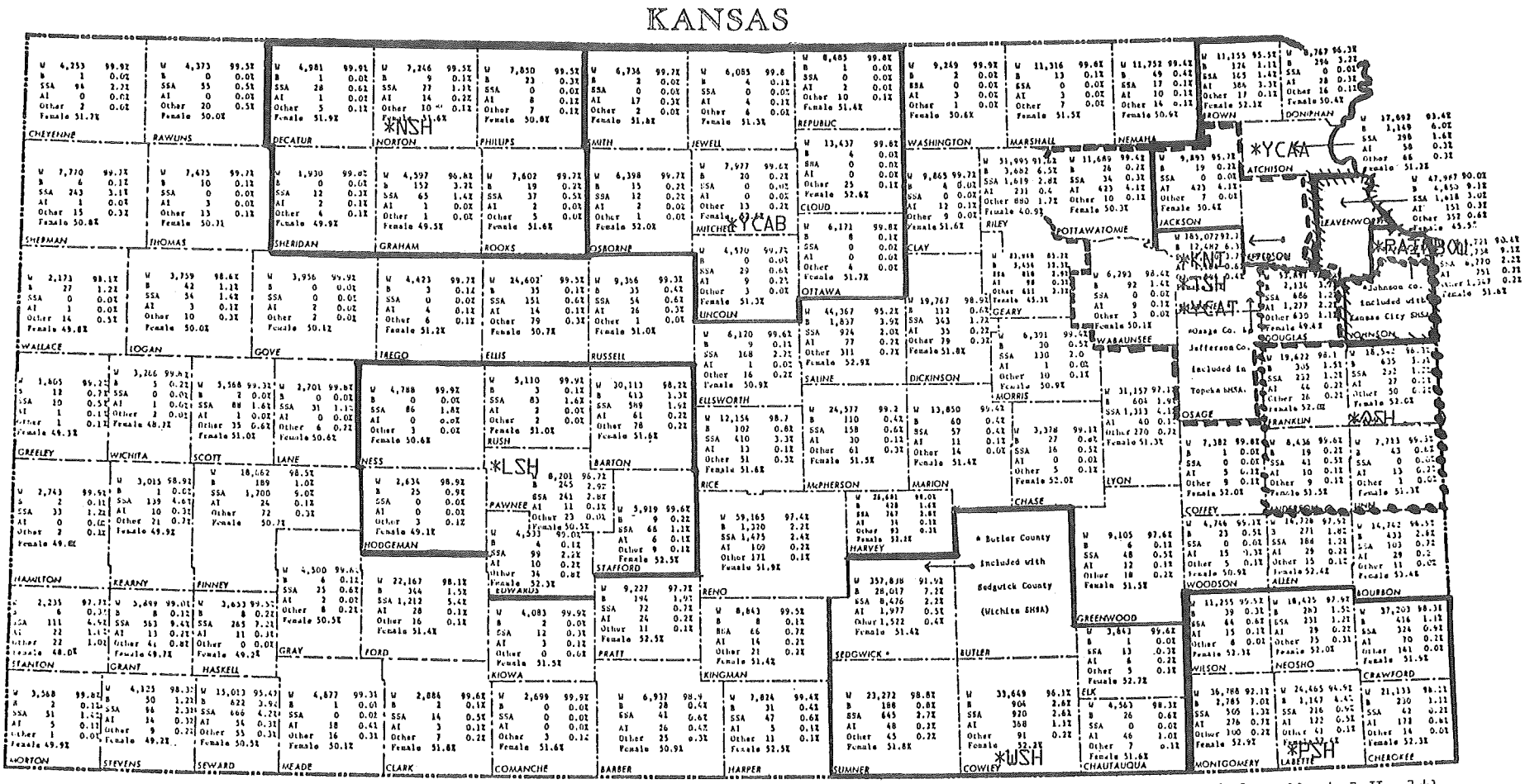


(Data compiled from 1970 U. S. Census)

6/78

COMPARATIVE CENSUS DATA BY RACE AND SEX FOR SRS INSTITUTIONS

The workforce within the commuting area surrounding each SRS institution may be compared with the average of the figures given for each county within the commuting area to determine such factors as underutilizations or over-concentrations in the workforce.



Commuting areas for each institution are outlined.

(Data compiled from 1970 U. S. Census)
6/78

*KNI=Kansas Neurological Institute
*LSH=Larned State Hospital
*NSH=Norton State Hospital
*OSH=Osawatomie State Hospital
*PSH=Parsons State Hospit

*RAINBOW= Rainbow Mental Health Facility
*TSH=Topeka State Hospital
*WSH=Winfield State Hospital
*YCAB=Youth Center at Beloit
*YCAT & YCAA=Youth Center at Topeka and Atchison campuses

44 (d)

APPENDIX G

SRS EEO REPORT FORMS

SRS Form #608 (Revised 2/76)

DEPT. OF SOCIAL & REHABILITATION SERV.
AFFIRMATIVE ACTION PROGRAM
- Job Applicant Record -

47 (a)

1. Agency:_____
2. Org. Unit:_____
3. Time Period:_____
4. Position No:_____
5. Class Title:_____
6. Class Code:_____
7. EEO Code:_____
8. Person preparing report:_____
_____

9. ☐ Permanent
☐ Temporary
☐ Emergency

10. Date	11. Name	12. Race	13. Sex	14. Ref. Source	15. Disposition	16. Date of Hire	17. Rate of Pay	18. Reason for Decision

PLEASE PRINT OR TYPE
SEE INSTRUCTIONS ON BACK

(Replaces EEO Tabl)

INSTRUCTIONS FOR COMPLETING SRS
Form #608 (Revised 2/76)
Job Applicant Record

SRS Form 608 (Revised 2/76) has been redesigned for use in meeting State EEO quarterly reporting requirements. In addition, it still provides a written record of why one applicant was selected over others and is necessary to satisfy other EEO record-keeping requirements. These forms are not to be included as part of any employees' personnel file. One form should be completed for every position for which applicants are interviewed. Only those persons actually interviewed should be listed. The form should be completed for temporary and emergency appointments as well as regular permanent positions. At present EEO does not require the reporting of temporary or emergency appointment information, however, the forms should be completed and retained in the area office or institution. Such forms will be required in the event an EEO or Civil Rights complaint investigation is necessary.

1. Agency - Enter name of institution, area office, SRS Division, Central office section, etc.
2. Organizational Unit - Enter name of appropriate organizational sub-unit in which the position is located.
3. Time period - Enter the reporting period (i.e. December 18 - March 17; March 18 - June 17; June 18 - September 17; September 18 - December 17).
4. Position number - Enter the nine (9) digit number assigned to the position (i.e. 03-01-00-001).
5. Class Title - Enter the official class title to which the position is allocated (i.e. Clerk Typist II).
6. Class Code - Enter the four (4) digit payroll code of the class, (i.e. 1022 for Clerk Typist II).
7. EEO Code - Enter the appropriate E.E.O. Code (i.e. "F" for Clerk Typist II).
8. Person Completing the Report - Enter the name of the person responsible for completion of the form, not the person typing the form.
9. Permanent, Temporary, Emergency - Check the appropriate box as applies to this position.
10. Date - Enter the date individual was interviewed.
11. Name - Enter name of individual interviewed.
12. Race - Enter race of individual interviewed. NOTE: The interviewer should not ask the applicant his or her race. This entry is to be made only on the basis of observation. Use those code designations approved by the Department of Administration.
13. Sex - Enter code designations "M" for male, or "F" for female.
14. Referral Source - The following codes may be used in reporting this information:
    1. Civil Service Register
    2. Agency promotional opportunity bulletin
    3. Agency application file
    4. Walk-in
    5. Referral from Job Opportunity Center
    6. Referral from minority organization
    7. Referral by agency employee
    8. Response to newspaper or other public media advertisement.
    9. Other
15. Disposition - Use the following codes when completing this block:
    1. Interviewed, No offer
    2. Interviewed, Offer extended and hired
    3. Interviewed, Offer extended but rejected.
16. Date of Hire - First day on the payroll in this position.
17. Rate of Pay - Enter salary figure at which applicant was appointed. A dollar amount should be indicated.
18. Reason for Decision - These comments should indicate why a particular applicant was hired and why the others were not hired.

Questions concerning the completion of this form may be referred to the SRS Personnel Management Section.

OCIAL AND REHABILITATION SERVICES
eporting Period ______________________
age ________ of ________
rg. Unit: ______________________

TABULATION WORKSHEET
State Affirmative Action Applicant Flow Report
(TABLE I)

Position Number	Class Code	EEO Code	Total Interviewed	Race Codes						Sex		Referral Source									Disposition			Appointee		Date of Hire	Rate of Pay
				1	2	3	4	5	6	M	F	1	2	3	4	5	6	7	8	9	1	2	3	Sex	Race		

SRS Form #608 '#) (12/76)

INSTRUCTIONS FOR COMPLETING SRS
Form #608 (Revised 2/76)
Job Applicant Record

SRS Form 608 (Revised 2/76) has been redesigned for use in meeting State EEO quarterly reporting requirements. In addition, it still provides a written record of why one applicant was selected over others and is necessary to satisfy other EEO record-keeping requirements. These forms are not to be included as part of any employees' personnel file. One form should be completed for every position for which applicants are interviewed. Only those persons actually interviewed should be listed. The form should be completed for temporary and emergency appointments as well as regular permanent positions. At present EEO does not require the reporting of temporary or emergency appointment information, however, the forms should be completed and retained in the area office or institution. Such forms will be required in the event an EEO or Civil Rights complaint investigation is necessary.

1. Agency - Enter name of institution, area office, SRS Division, Central office, section, etc.
2. Organizational Unit - Enter name of appropriate organizational sub-unit in which the position is located.
3. Time period - Enter the reporting period (i.e. December 18 - March 17; March 18 - June 17; June 18 - September 17; September 18 -December 17).
4. Position number - Enter the nine (9) digit number assigned to the position (i.e. 03-01-00-001).
5. Class Title - Enter the official class title to which the position is allocated (i.e. Clerk Typist II).
6. Class Code - Enter the four (4) digit payroll code of the class, (i.e. 1022 for Clerk Typist II).
7. EEO Code - Enter the appropriate E.E.O. Code (i.e. "F" for Clerk Typist II).
8. Person Completing the Report - Enter the name of the person responsible for completion of the form, not the person typing the form.
9. Permanent, Temporary, Emergency - Check the appropriate box as applies to this position.
10. Date - Enter the date individual was interviewed.
11. Name - Enter name of individual interviewed.
12. Race - Enter race of individual interviewed. NOTE: The interviewer should not ask the applicant his or her race. This entry is to be made only on the basis of observation. Use those code designations approved by the Department of Administration.
13. Sex - Enter code designations "M" for male, or "F" for female.
14. Referral Source - The following codes may be used in reporting this information:
    1. Civil Service Register
    2. Agency promotional opportunity bulletin
    3. Agency application file
    4. Walk-in
    5. Referral from Job Opportunity Center
    6. Referral from minority organization
    7. Referral by agency employee
    8. Response to newspaper or other public media advertisement.
    9. Other
15. Disposition - Use the following codes when completing this block:
    1. Interviewed, No offer
    2. Interviewed, Offer extended and hired
    3. Interviewed, Offer extended but rejected.
16. Date of Hire - First day on the payroll in this position.
17. Rate of Pay - Enter salary figure at which applicant was appointed. A dollar amount should be indicated.
18. Reason for Decision - These comments should indicate why a particular applicant was hired and why the others were not hired.

Questions concerning the completion of this form may be referred to the SRS Personnel Management Section.

AFFIRMATIVE ACTION PROGRAM
TRAINING

TABLE II

Agency _____
Organizational Unit _____
Time Period _____
Person Preparing Data _____

Type of Training	Name of Participant	Race	Sex	Duration of Training	Date Completed	Job Before Training	Pay Before Training	Job After Training If same, so state	Pay After Training If same, so state

SUBMIT AT END OF EACH FISCAL QUARTER TO
DIRECTOR OF EQUAL EMPLOYMENT OPPORTUNITY

AFFIRMATIVE ACTION PROGRAM
PROMOTION, TRANSFER AND
DEMOTION DATA
TABLE III

Agency _____
Organizational Unit _____
Time Period _____
Person _____

Complete only if promoted or transferred

DATE	NAME	RACE	SEX	Present Position	Present Pay	EEO Category	Disposition*	New Position	New Org. Unit	New Dept. Name & No.	New EEO Category	Sal. chg. + or -	T# or P

* 1 - Interviewed
2 - Not Interviewed
3 - Interviewed, but no chance

\# T - Transfer
P - Promotion
SUBMIT AT END OF EACH FISCAL QUARTER TO
DIRECTOR OF EQUAL EMPLOYMENT OPPORTUNITY

AFFIRMATIVE ACTION PROGRAM
TERMINATION DATA

TABLE IV

Agency _____
Organizational Unit _____
Time Period _____
Person Preparing Data _____

DATE	NAME	RACE	SEX	Date of Initial Hire	Pos. at Time of Term.	Date of Term.	EEO Category	Org. Unit separated from	Dept. & no. term. from	Reason for Termination

SUBMIT AT END OF EACH FISCAL QUARTER TO
DIRECTOR OF EQUAL EMPLOYMENT OPPORTUNITY

Office or Institution _____

Date _____ _____

CONSOLIDATED EMPLOYEE REPORT - TABLE VII

Submit at end of each fiscal quarter to Director of Equal Employment Opportunity.

JOB CATEGORY	(1) WHITE			(2) BLACK			(3) HISPANIC-SSA			(4) AMERICAN INDIAN ALASKAN NATIVE			(5) ASIAN (ORIENTAL)			TOTAL MINORITY EMPLOYEES			TOTALS		
Officials and	M	F	Tot.	M	F	Tot.	M	F	Tot.	M	F	Tot.	M	F	Tot.	M	F	TOT.	M	F	Total
(A) Administrators																					
Percentage																					
(B) Professionals																					
Percentage																					
(C) Technicians																					
Percentage																					
(D) Protective																					
Service-Security																					
Percentage																					
(E) Paraprofessionals																					
Percentage																					
(F) Office and																					
Clerical																					
Percentage																					
(G) Skilled Crafts																					
Percentage																					
(H) Service and																					
Maintenance																					
Percentage																					
TOTALS																					
Percentage																					

AGENCY _____
DATE _____

EMPLOYEE ANALYSIS BY JOB CATEGORY AND CLASSIFICATION

JOB CATEGORY	ALL EMPLOYEES TOTAL	ALL EMPLOYEES MALE	ALL EMPLOYEES FEMALE	MINORITY GROUP EMPLOYEES MALE BLACK	MALE SSA	MALE Amer. Ind.	MALE Orien-tal	MALE Other	FEMALE BLACK	FEMALE SSA	FEMALE Amer. Ind.	FEMALE Orien-tal	FEMALE Other
OFFICIALS AND ADMINISTRATORS (A)													
Accountant IV													
Accountant V													
Administrative Intern													
Administrative Officer I													
Administrative Officer II													
Administrative Officer III													
Administrator, Rainbow Unit													
Alcoholism Field Ser. Adm.													
Alcoholism Trg. & Ed. Dir.													
Asst. Dir. Com. on Alcoh.													
Asst. Dir., MHRS													
Chief of Adm. Serv. Welf.													
Chief of Inc. Main.													
Chief of Reg. Oper.													
Chief of Soc. Serv.													
Coord. Inst. Res. & Trg.													
Coord. Med. Serv. (SW)													
Dietetic Consultant													
Dir. of Adm. Serv.													
Dir. Alcoh. & Drug Abuse													
Dir. Chaplaincy Serv.													
Dir. Child Care Serv.													
Dir. Comm. MH Serv.													
Dir. of Food Programs													
Dir. St. EEO Office													
Foster Grand. Prog. Coord.													
Inc. Maint. Adm.													
Inst. Fire Chief													
Media Production Dir.													
Med. Care Prog. Adm.													
Personnel Officer III													

JOB CATEGORY	ALL EMPLOYEES TOTAL	ALL EMPLOYEES MALE	ALL EMPLOYEES FEMALE	MINORITY GROUP EMPLOYEES BLACK	MALE SSA	MALE Amer. Ind.	MALE Orien-tal	MALE Other	FEMALE BLACK	FEMALE SSA	FEMALE Amer. Ind.	FEMALE Orien-tal	FEMALE Other
OFFICIALS AND ADMINISTRATORS (A)													
Personnel Officer V													
Psy. Hosp. Med. Rec. Adm.													
Social Serv. Adm. I													
Social Serv. Adm. II													
Social Serv. Adm. III													
Social Serv. Adm. IV													
Supr. of Rehab. Cent. for Blind													
Superintendents (Unclassified)													
Clinical Director (Unclassified)													
PROFESSIONALS (B)													
Accountant I													
Accountant II													
Accountant III													
Act. Therapies Supr.													
Act. Therapist I													
Act. Therapist II													
Adm. Voc. Rehab. Cent.													
Alcoholism Counselor													
Alcoholism Field Rep.													
Alcoholism Program Spec.													
Alcoholism Unit Dir.													
Architect III													
Asst. Supr. Dis. Deter.													
Attorney I													
Attorney II													
Attorney III													
Auditor I													
Auditor II													
Auditor III													
Bus. Enter. Supr.													
Clinical Chaplain I													
Clinical Chaplain II													
Comm. Program Cons. I													
Comm. Program Cons. II													
Computer Sys. Analyst													
Coord. of Child. Serv.													
Coord. Coop. Rehab. Prg.													

JOB CATEGORY	ALL EMPLOYEES TOTAL	ALL EMPLOYEES MALE	ALL EMPLOYEES FEMALE	MINORITY GROUP EMPLOYEES MALE BLACK	MALE SSA	MALE Amer. Ind.	MALE Orien-tal	MALE Other	MINORITY GROUP EMPLOYEES FEMALE BLACK	FEMALE SSA	FEMALE Amer. Ind.	FEMALE Orien-tal	FEMALE Other
PROFESSIONALS (B)													
Dentist													
Dietitian I													
Dietitian II													
Dietitian III													
Disability Examiner I													
Disability Examiner II													
Education Director													
Education Program Specialist													
Equal Emply. Opport. Officer													
Field Supr. Voc. Rehab.													
Fire, Safety & San. Cons.													
Gen. Mgr. Indus. f/t Blind													
Graduate Nurse I													
Graduate Nurse II													
Graduate Nurse III													
Group Care Spec.													
Home Teacher f/t Blind													
Inc. Maint. Worker I													
Inc. Maint. Worker II													
Inc. Maint. Worker III													
Indus. Therapy Coord.													
Inst. Educator I													
Inst. Educator II													
Instr. f/t Blind													
Interviewer I													
Librarian I													
Management Analyst I													
Nursing Consultant													
Ophthalmology Consultant													
Personnel Officer I													
Personnel Officer II													
Pharmacist I													
Pharmacist II													
Procurement Officer I													
Procurement Officer II													
Psychiatric Nurse I													
Psychiatric Nurse II													

JOB CATEGORY	ALL EMPLOYEES TOTAL	ALL EMPLOYEES MALE	ALL EMPLOYEES FEMALE°	MINORITY GROUP EMPLOYEES MALE BLACK	MALE SSA	MALE Amer. Ind.	MALE Orien-tal	MALE Other	FEMALE BLACK	FEMALE SSA	FEMALE Amer. Ind.	FEMALE Orien-tal	FEMALE Other
PROFESSIONALS (B)													
Psychiatric Nurse III													
Psychologist I													
Psychologist II													
Psychologist III													
Public Relations Director I													
Reimbursement Officer I													
Reimbursement Officer II													
Research Analyst I													
Research Analyst II													
Research Analyst III													
Research Analyst IV													
Sales Mgr. Blind Made Products													
Sheltered Wrkshp. Manager													
Sheltered Wrkshp. Tech. I													
Sheltered Wrkshp. Tech. II													
Social Worker I													
Social Worker II													
Social Worker III													
Social Worker IV													
Social Worker V													
Social Worker VI													
Social Work Instructor													
Speech Pathologist I													
Speech Pathologist II													
Speech Pathology Spec.													
Supr. of Dis. Deter.													
Sys. Analysis & Prg. Mngr. EDP													
Vocational Evaluator													
Vocational Instructor													
Voc. Rehab. Counselor													
Voc. Rehab. Supr. I													
Voc. Rehab. Supr. II													
Volunteer Serv. Coord.													
Voc. Trng. Supr.													
Wrkshp. Mgr. Industries f/t Blind													

JOB CATEGORY	ALL EMPLOYEES TOTAL	ALL EMPLOYEES MALE	ALL EMPLOYEES FEMALE	MINORITY GROUP EMPLOYEES BLACK	MALE SSA	MALE Amer. Ind.	MALE Orien-tal	MALE Other	FEMALE BLACK	FEMALE SSA	FEMALE Amer. Ind.	FEMALE Orien-tal	FEMALE Other
TECHNICIANS (C)													
Audio Visual Ed. Tech.													
Barber													
Computer Operator													
Comp. Opr. Contr. Supr.													
Cosmetologist													
Dental Assistant													
Drug Clerk													
Electroencephalograph Tech.													
Electronics Tech. I													
Electronics Tech. II													
Homemaker													
Laboratory Tech. I													
Media Production Tech.													
Medical Technician I													
Medical Technician II													
Medical Technologist I													
Medical Technologist II													
Mental Health Technician													
Microbiologist I													
Microbiologist II													
Operating Room Technician													
Patrolman Lieutenant													
Photographer I													
Practical Nurse													
Programmer I													
Programmer II													
Programmer III													
Psychometric Technician													
Rad. Tech. I, Diag. X-Ray													
Tape Librarian													
Upholstery & Shoe Repairman													

JOB CATEGORY	ALL EMPLOYEES TOTAL	ALL EMPLOYEES MALE	ALL EMPLOYEES FEMALE	MINORITY GROUP EMPLOYEES BLACK	MALE SSA	MALE Amer. Ind.	MALE Orien-tal	MALE Other	FEMALE BLACK	FEMALE SSA	FEMALE Amer. Ind.	FEMALE Orien-tal	FEMALE Other
PROTECTIVE SERVICE WORKERS (D)													
Correctional Officer I													
Correctional Officer II													
PARAPROFESSIONALS (E)													
Act. Therapy Aide I													
Act. Therapy Aide II													
Act. Therapy Aide III													
Act. Therapy Trainee													
Clinical Pastoral Trainee													
Cottage Parent I													
Cottage Parent II													
Foster Grandparent (Federal)													
Foster Grandparent (State)													
Hospital Attendant													
Hospital Attendant Supr.													
Hospital Attendant Trainee													
Hospital Trainee													
Library Assistant													
Library Clerk													
Program Aide (Disadv.)													
Program Worker I (Disadv.)													
Program Worker II (Disadv.)													
Psychiatric Aide I													
Psychiatric Aide II													
Psychiatric Aide III													
Psychiatric Aide IV													
Psy. Security Aide I													
Psy. Security Aide II													
Psychology Trainee													
Pub. Serv. Car. Trainee													
Social Worker Aide													
Social Worker Trainee													

JOB CATEGORY	ALL EMPLOYEES TOTAL	MALE	FEMALE	MINORITY GROUP EMPLOYEES MALE BLACK	SSA°	Amer. Ind.	Orien-tal	Other	FEMALE BLACK	SSA	Amer. Ind.	Orien-tal	Other
OFFICE AND CLERICAL (F)													
Account Clerk I													
Account Clerk II													
Account Clerk III													
Addressograph Operator													
Bookkeep. Machine Operator													
Cashier													
Clerk I													
Clerk II													
Clerk III													
Clerk IV													
Clerk V													
Clerk Steno I													
Clerk Steno II													
Clerk Typist I													
Clerk Typist II													
Data Entry Equip. Opr. I													
Data Entry Equip. Opr. II													
Data Entry Supr.													
Dupl. Mach. Oper. I													
Dupl. Mach. Oper. II													
Duplicating Supr. I													
Medical Records Tech.													
Messenger													
Motion Picture Proj.													
Secretary I													
Secretary II													
Secretary III													
Storekeeper I													
Storekeeper II													
Storekeeper III													
Switchboard Operator I													
Switchboard Operator II													
Switchboard Operator III													

JOB CATEGORY	ALL EMPLOYEES TOTAL	ALL EMPLOYEES MALE	ALL EMPLOYEES FEMALE	MINORITY GROUP EMPLOYEES MALE BLACK	MALE SSA	MALE Amer. Ind.	MALE Orien-tal	MALE Other	FEMALE BLACK	FEMALE SSA	FEMALE Amer. Ind.	FEMALE Orien-tal	FEMALE Other
SKILLED CRAFT WORKERS (G)													
Automotive Driver													
Automotive Mechanic I													
Automotive Mechanic II													
Automotive Serviceman													
Equipment Operator I													
Equipment Operator II													
Equipment Operator III													
Lock System Spec.													
Machinist													
Maint. Carpenter													
Maint. Carpenter Foreman													
Maint. Electrician													
Maint. Elect. Foreman													
Maint. Engineer I													
Maint. Engineer II													
Maint. Engineer III													
Maintenance Mason													
Maintenance Painter													
Maint. Painter Foreman													
Maintenance Plumber													
Maint. Plumber Foreman													
Maintenance Repairman													
Refrig. & Air Cond. Mech.													
Sheet Metal Worker													
Stationary Fireman													
Steam Fitter													
Welder													
SERVICE - MAINTENANCE (H)													
Baker													
Cook I													
Cook II													
Custodial Supr. I													
Custodial Supr. II													

JOB CATEGORY	TOTAL	MALE	FEMALE	MINORITY GROUP EMPLOYEES									
					MALE					FEMALE			
				BLACK	SSA	Amer. Ind.	Orien-tal	Other	BLACK	SSA	Amer. Ind.	Orien-tal	Other
SERVICE - MAINTENANCE (H)													
Custodial Worker													
Domestic Worker													
Exec. Housekeeper I													
Exec. Housekeeper II													
Exec. Housekeeper III													
Fire & Safety Officer													
Florist													
Food Serv. Supr. I													
Food Serv. Supr. II													
Food Serv. Worker I													
Food Serv. Worker II													
Gardener													
Laborer I													
Laborer II													
Laborer Foreman I													
Laborer Foreman II													
Laundry Foreman I													
Laundry Foreman II													
Laundry Worker													
Meat Cutter													
Nurseryman													
Seamstress I													
Seamstress II													
Security Officer I													
Security Officer II													

EMPLOYEE ANALYSIS BY JOB CATEGORY

	AGE													HANDICAP																			
JOB CATEGORY	0-17 yrs.	18-20 yrs.	21-24 yrs.	25-29 yrs.	30-34 yrs.	35-39 yrs.	40-44 yrs.	45-49 yrs.	50-54 yrs.	55-59 yrs.	60-65 yrs.	66-70 yrs.	71 & over	1. Epilepsy	2. Diabetes	3. Cardiac	4. Arthritis	5. Loss of hearing	6. Loss of sight-visual	7. Cancer	8. Cerebral palsy	9. Multiple Sclerosis	10. Parkinson's Disease	11. Cerebral Vascular	12. Tuberculosis	13. Silicosis, asbestosis or other occupational disease	14. Psycho-Neurotic or Mental Disorder	15. Loss or partial loss of use of any member of body	16. Any Physical deformity or abnormality or Orthopedic Impairment	17. Muscular Dystrophy	18. Alcoholism or Drug Addiction	19. Mental Retardation	20. Any other physical or mental impairment substantially limiting 1 or more life activities
(A)																																	
Officials &																																	
Administrators																																	
Percentage																																	
(B)																																	
Professionals																																	
Percentage																																	
(C)																																	
Technicians																																	
Percentage																																	
(D)																																	
Protective																																	
Service-Security																																	
Percentage																																	

Over

EMPLOYEE ANALYSIS BY JOB CATEGORY

JOB CATEGORY	AGE													HANDICAP																				
	0-17 yrs.	18-20 yrs.	21-24 yrs.	25-29 yrs.	30-34 yrs.	35-39 yrs.	40-44 yrs.	45-49 yrs.	50-54 yrs.	55-59 yrs.	60-65 yrs.	66-70 yrs.	71 & over	1. Epilepsy	2. Diabetes	3. Cardiac	4. Arthritis	5. Loss of hearing	6. Loss of sight-visual	7. Cancer	8. Cerebral palsy	9. Multiple Sclerosis	10. Parkinson's Disease	11. Cerebral Vascular	12. Tuberculosis	13. Silicosis, asbestosis or other occupational disease	14. Psycho-Neurotic or Mental Disorder	15. Loss or partial loss of use of any member of body	16. Any Physical deformity or abnormality or Orthopedic Impairmen.	17. Muscular Dystrophy	18. Alcoholism or Drug Addiction	19. Mental Retardation	20. Any other physical or mental impairment substantially limiting 1 or more life activities
(E) Paraprofessionals																																		
Percentage																																		
(F) Office and Clerical																																		
Percentage																																		
(G) Skilled Craft																																		
Percentage																																		
(H) Service & Maintenance																																		
Percentage																																		
TOTAL																																		
Percentage																																		

SOCIAL AND REHABILITATION SERVICES
EQUAL EMPLOYMENT OPPORTUNITY
COMPLAINT OF DISCRIMINATION

SRS Form #618
(4-77)

THIS FORM IS TO BE FILED WITH YOUR EEO REPRESENTATIVE. (Please read reverse side before completing)

STATE OF KANSAS
DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

(For Department Use)
EEO Complaint Case Number_____

Name of EEO Representative Contacted:

On the Complaint of

_____ vs. _____
Complainant's Name

Respondent-Division, Institution, Office or Section

_____
Address

_____
Phone

_____
Address

I,_____ charge_____
Complainant's Name

with an alleged practice of discrimination because of:

Race ☐ Religion ☐ Color ☐ Sex ☐ Age ☐

Handicap ☐ National Origin ☐ Ancestry ☐

Date of incident, on or about_____ 19___.

The facts on which the aforesaid charge is based are as follows: (please include specific dates, places, names of individuals and circumstances in alleged unlawful employment practice. If more space is needed, please continue on reverse side).

What corrective action are you seeking?

_____
Date of this complaint

_____
Complainant's Signature

PLEASE READ CAREFULLY

This form should be used if you feel that you have been discriminated against because of race, religion, color, sex, national origin, ancestry, handicap or age, and filed with your SRS EEO Representative or the Department EEO Officer.

If assistance is needed in preparation of a complaint, contact an EEO Representative or the Department EEO Officer.

The Affirmative Action Plan of the department provides equal employment opportunity to individuals seeking employment with this department and to those persons currently employed by this department. The department is committed to investigate a complaint of alleged discrimination and to correct discriminatory practices.

If you feel your complaint has not received proper and corrective action you may wish to file with one or more of the following agencies:

Type of Discrimination	Agency	Time Limit For Filing
Race, Color, Religion, Sex or National Origin	The U.S. Equal Employment Opportunity Commission Regional Office 601 East 12 Street, Room 112 Kansas City, Missouri 64106	within 180 days from the date of incident
Race, Religion, Color, Sex, National Origin, Ancestry or Physical Handicap	Kansas Commission on Civil Rights Fifth Floor 535 Kansas Avenue Topeka, Kansas 66603	within 180 days from the date of incident
Age	U.S. Department of Labor Employment Administration, Wage and Hour Division Direct questions to your local office the Department of Labor, Wage and Hour Division	within 180 days after alleged unlawful practice occurred. (See Age Discrimination in Employment Act of 1967
Handicap	U.S. Department of Labor Employment Standards Administration Office of Federal Contract Compliance Programs	within 180 days from the date of alleged violation (See Section 503 of the Rehabilitation Act of 1973

SUMMARY OF SRS APPLICANT FLOW

Position Classification	Total Inter-viewed	M	F	White	Black	Spanish Surnamed American	American Indian	Oriental	Interviewed Offered job Job offer rejected	Number Hired	Race Hired

SRS WANTS YOU TO KNOW . . .

equal employment opportunity is the law

WITHOUT REGARD TO

RACE, RELIGION, COLOR, SEX, NATIONAL ORIGIN, ANCESTRY HANDICAP, AGE, or POLITICAL AFFILIATION

IN

Recruitment ● Hiring ● Placement ● Promotion ● Benefits
Transfer ● Compensation ● Training and Apprenticeship ● Aides
Services ● Layoff ● Termination ● Physical Facilities

Section 504 of the Rehabilitation Act of 1973 prohibits discrimination because of handicap. Questions in this regard should be directed to the

U.S. Department of HEW
Office of Civil Rights
1150 Grand Avenue, 7th Floor
Kansas City, Missouri 64106

Title VII of the Civil Rights Act of 1964, as amended, prohibits job discrimination because of race, color, religion, sex or national origin.

Applicants to and employees of private employers, state/local governments, and public/private educational institutions are protected. Also covered are employment agencies, labor unions and apprenticeship programs. Any person who believes he or she has been discriminated against should contact immediately

The U.S. Equal Employment Opportunity Commission (EEOC)
K.C. District Office
1150 Grand Ave.
Kansas City, Missouri 64106

State and Federal laws and regulations prohibit discrimination because of political affiliations. Questions may be directed to the

Local U.S. Department of Labor Office of Federal Contract Compliance or
HEW Office of Civil Rights

The Age Discrimination in Employment Act prohibits arbitrary age discrimination in employment. If you feel you have been discriminated against because of age, contact the

U.S. Department of Labor
Wage and Hour Division, Regional Office
911 Walnut Street
Kansas City, Missouri 64106

Kansas Law provides Equal Opportunity without regard to race, religion, color, sex, physical handicap, national origin or ancestry. Report discrimination to:

Kansas Commission on Civil Rights
535 Kansas Ave., 5th Floor **212 South Market**
Topeka, Kansas 66603 **Wichita, Kansas 67202**

(K.S.A. 44-1005 requires all complaints be filed within six months after the alleged act of discrimination.)

Executive Order 11246, as amended, prohibits job discrimination because of race, color, religion, sex or national origin and requires affirmative action to ensure equality of opportunity in all aspects of employment.

Section 503 of the Rehabilitation Act of 1973 prohibits job discrimination because of handicap and requires affirmative action to employ and advance in employment qualified handicapped workers.

Section 402 of the Vietnam Era Veterans' Readjustment Assistance Act of 1974 prohibits job discrimination and requires affirmative action to employ and advance in employment (1) qualified Vietnam era veterans during the first four years after their discharge and (2) qualified disabled veterans throughout their working life if they have a 30 percent or more disability.

Applicants to and employees of any company with a federal government contract or subcontract are protected. Any person who believes a contractor has violated its affirmative action obligations, including nondiscrimination, under Executive Order 11246, as amended, or under Section 503 of the Rehabilitation Act should contact immediately

The Employment Standards Administration
Office of Federal Contract Compliance Programs (OFCCP)
911 Walnut Street
Kansas City, Missouri 64106

Local Information:

ALL COMPLAINTS MUST BE FILED WITHIN 180 DAYS FROM DATE OF ALLEGED VIOLATION

HUMAN RIGHTS COMMITTEE--SPECIAL SECURITY UNIT/MENTALLY RETARDED

FUNCTION

To establish an ongoing process of defining the general needs of the difficult-to-manage mental retardate and to ensure that all of his rights are protected as provided by the Kansas Statutes. In order to promote a broader base for understanding this task, persons of various backgrounds and work experiences will be chosen so that input is adequate and relevant.

Composition: (Chairman to be elected from membership)

Superintendent of L.S.H.
Community Minister
Local citizens, representatives from organizations for MR/DD
Physician
Psychologist
Registered Nurse
Activity Therapist, S.S.H.
Director of Youth Services
Social Worker, L.S.H.
Educator, L.S.H
Recording Secretary

Resource Persons, SSU/MR: (Non-voting)

Unit Nurse Coordinator
Treatment Team Leader
Psychologist
Activity Therapist
Ward Nurse
Physician
Ward Council Advisor

APPROVED BY: Hildreth Hultine DATE: 11-20-79
Hildreth Hultine, Superintendent

No. 2.02 C

HUMAN RIGHTS COMMITTEE

PHILOSOPHY

In order to enhance the learning process regarding the needs of all persons involved in the giving and receiving of mental health care, this administration encourages citizens in the community and the state to become participants in the function of ensuring the protection of human rights of those who are hospitalized for the purpose of receiving treatment or being evaluated to determine need for treatment. We pledge to work together to provide a therapeutic environment where those who are hospitalized at Larned State Hospital will obtain quality treatment in the least restrictive manner possible.

Every individual will receive treatment that shall be impartial; free from discrimination by race, religion, sex, ethnicity, age or handicap.

PURPOSE

1. To involve citizens of the community in the process of preventing violation of human rights of all persons receiving treatment, evaluation and/or education at this institution;

2. To serve as a method for improving staff/patient interaction and communication;

3. To provide a forum so the patient may be heard and his human need for acceptance perceived;

4. To determine program-planning needs;

5. To promote a stable, therapeutic environment;

6. To establish the mechanics required for creating and maintaining a climate conducive to recovery; and,

7. To enhance the patient's capacity for responsibility and initiative.

Membership: The membership of the Human Rights Committee shall consist of a patient representative from the treatment unit (usually the chairman of Ward Government or another person selected by the patients).

The Superintendent shall select a minimum of four other staff persons not to exceed more than six staff. The Superintendent shall select a minimum of three citizens.

Meetings: Meetings shall be held monthly or at the request of any three members. Minutes shall be recorded with copies sent to each ward and other members.

APPROVED BY: Hildreth Hultine DATE: 12-10-79

Hildreth Hultine, Superintendent

FORM 405
520-T

To Dr. Harder

STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

MEMORANDUM

FROM: K. G. Keller

RE:

DATE: February 1, 1980

The notice that tells employees that they were free to meet with the legislative investigating committee has been posted all week in every cottage at Atchison. They have a weekly calendar that is published on Thursday that is posted on every cottage bulletin board. Gene conducts a communications meeting every Monday morning to which everyone who is available is invited. Notes of that meeting are posted on every cottage bulletin board and in this instance included the notice of employees right to appear before the committee.

KGK:d

Dr Harder

YOUTH CENTER AT ATCHISON

ATCHISON, KANSAS

DIVISION OF MENTAL HEALTH AND RETARDATION SERVICES
FEB 1 1980

STATE DEPT. OF SOC. REHAB. SERV.

TO: Ken Keller

FROM: Terry Kearns

MEMORANDUM

STATE DEPT. OF SOC. REHAB. SERV.
FEB 1 1980
RECEIVED
SECRETARY'S OFF.

DATE: January 31, 1980

SUBJECT: Dr. Harder's letter of January 25, 1980

Mr. Wilson asked me today to inform you of how the Youth Center at Atchison complied with the instructions given in Dr. Harder's letter of January 25, 1980, pertaining to notification of all employees of their opportunity to testify before the Special Study Committee.

In our Monday, January 28, 1980, Communication Meeting, I announced that we had received a letter from Dr. Harder along with an enclosure from Robert A. Coldsnow. I proceeded to read Mr. Coldsnow's letter in its entirety. There was a question from Mr. Stobbe and then a comment from Mr. Penny before we proceeded to other business.

Minutes of the Communication Meeting taken by Vicki Jones were typed and distributed on the same day, January 28, 1980. Included in these minutes is my announcement stating how employees may make an appointment to testify before the Special Committee. I am enclosing a copy of the Communication Meeting minutes along with a list of individuals to whom the minutes are distributed. Also enclosed is a list of our staff who were in attendance of the Communication Meeting January 28, 1980.

In order to assure that all employees become aware of their opportunity to testify before the Special Study Committee, we decided to make a notation under the Announcements section of our YCAA Weekly Calendar. The Calendar is normally distributed Thursday afternoon or Friday morning. This week's calendar is being distributed this afternoon (Thursday). A copy is enclosed along with list of staff and areas to which the Calendar is distributed.

vj

COMMUNICATION MEETING
January 23, 1980

Mr. Manly announced the Maintenance OD will be carrying his two-way radio while on campus on weekends so contact can be made easier. After-hours contact will have to be made through the telephone as the Maintenance OD will not take the radio off-campus such as to his home.

Dr. Kearns announced that the possibility is also being considered for the Clinical OD to carry a two-way radio on weekends.

Mr. Davidson announced there will be a basketball game Wednesday at 6:30 PM in the New Gym between the Youth Center team and a team from Kansas City, Missouri. Everyone is invited.

Dr. Kearns read a letter from the Honorable Robert A. Coldsnow who serves as the Legislative Counsel to the Legislature. The letter was sent to Dr. Harder instructing him to notify the hospitals and institutions that the study committee is underway. The study will involve all eleven of the social and rehabilitative institutions. The committee was appointed to study and review the management structure and utilization of personnel in state institutions operated by the Department of Social and Rehabilitation Services. All levels of personnel are free to contact the committee about matters pertinent to the study without fear of any retaliation or recrimination for contacting the committee or appearing before the committee. Personnel are to contact Robert Coldsnow at the State Capitol, Room 449-N, Topeka, phone number 913-296-3[illegible] to schedule a time for their appearance before the committee. Dr. Harder has directed any individual who wants to testify in person should make rescheduling arrangements or take annual leave for such testimony.

It was also announced that a memo should be distributed Tuesday regarding the classes at Benedictine College for [illegible] III's, IV's and V's.

vj

COPIES DISTRIBUTED OF
COMMUNICATION MEETING
&
YCAA WEEKLY CALENDAR

Dietary
maintenance
Hickory
Oak
Maple
Redwood
Cottonwood
Ivy
Kansans
Sequoia
Each Head Youth Service Worker (8)
Each Social Worker (4)
Each Psychologist (4)
Doris VanDyke
Barbara Wiley
John Tilghman
Bob Heintzelman
L. MacAlexander
school (3)
recreation (1 of Communication
& 4 of Calendar)
Nurse
Gary Kovar
Terry Kearns
Bill Vigola
Helen Vandiver
Mary Turner
Marian Whitenack
Karen Parker
file

ATTENDANCE AT COMMUNICATION
MEETING JANUARY 28, 1980

Yvonne Molineux
Peggy Roper
Mel Miller
M. L. Geisendorf
Verniss Haverkamp
Kirk Stobbe
Bill Vigola
Paul Manly
Doris VanDyke
Carl Davidson
Gil Hamilton
Mike Penny
Terry Kearns
Vicki Jones
Cookie Vigola
Gary Schooler
Dora Gregory
Ellen Cameron
Darrel Ray
Charlotte Houston

YCAA WEEKLY CALENDAR

February 2 - 8, 1980

ON-DUTY PERSONS FOR FEBRUARY 2-3, 1980
Clinical OD - Bill Vigola 367-1441 or 367-2622
Social Work OD - Mike Penny 367-3596
Maintenance OD - Kenny Moranz 367-0528

CASE CONFERENCES:

Tuesday		
ADAMS, Kenny (1 PM)	Program Planning	Oak Cottage
Wednesday		
CHANDLER, Kevin (10:30 AM)	Program Planning	Redwood Cottage
Thursday		
HERNANDEZ, Pete (1 PM)	Program Planning	Oak Cottage
Friday		
BOYER, Allen (1 PM)	Program Planning	Oak Cottage

BIRTHDAYS:
February 3 - Dick Wedel
4 - Edith Page - dietary
7 - Randy Gilbert
Verniss Haverkamp - Oak

NEW STAFF: Greg Steele, YSW IV, Kansan Cottage
Brian Green, half-time recreation staff

MEETINGS: The monthly YSW meeting will be held at 1 PM on Tuesday, February 5, in the Dining Hall.

SPECIAL ANNOUNCEMENT: Any staff wishing to discuss matters pertaining to the Youth Center or testify before the Special Study Committee should contact Robert Coldsnow, Room 449-N, Statehouse, Topeka 66612, phone number 913-296-3014 to schedule an appointment.

February 1, 1980

NOTE TO ALL PERSONNEL:

The Secretary of SRS, Dr. Robert Harder, has requested the Superintendent to advise all staff of a request by Senator Robert Talkington, Chairman of the 1980 Special Study Committee on SRS Institutions. The special committee was appointed by the Legislative Coordinating Council to study and review the management structure and utilization of personnel in all state institutions operated by SRS. There has been considerable publicity concerning activities at the Atchison Youth Center, the Rainbow Mental Health Facility, and the Osawatomie State Hospital, but members of the committee wish to make it clear that the study would involve all eleven institutions. These activities primarily involve the topics of alcohol, drugs, sex, child abuse, and other unacceptable behavior of SRS employees. Senator Talkington and members of the committee also wanted to make it clear to all personnel that they are free to contact the committee about matters pertinent to the study without fear of any retaliation or recrimination for contacting the committee or appearing before the committee. All personnel should contact Robert A. Coldsnow, who serves as the Legislative Counsel to the Legislature, Room 449-N, Statehouse, Topeka, Kansas, 66612, if they desire to make any presentation to the committee.

Gary J. Daniels, Ph.D.
Superintendent

STATE OF KANSAS
JOHN CARLIN, Gov.

SOCIAL AND
REHABILITATION SERVICES
STATE OFFICE BLDG
TOPEKA, KANSAS 66612
ROBERT C. HARDER, Secy.

PARSONS STATE HOSPITAL AND TRAINING CENTER
2601 Gabriel
PARSONS, KANSAS 67357
GARY J. DANIELS, Ph.D., Supt.

January 31, 1980

Routed through Mental Health
and Retardation Services

Dr. Robert Harder, Secretary
Department of Social and Rehabilitation Services
State Office Building
Topeka, KS 66612

Dear Dr. Harder:

Please find the enclosed note to all personnel of Parsons State Hospital and Training Center. This note was placed in the pay envelopes of all employees.

I hope that you find this to be a satisfactory response to the request made by Senator Talkington.

Sincerely,

Gary J. Daniels, Ph.D.
Superintendent

GJD:bk
encl.

No. 2.03

WARD GOVERNMENT

RULES AND REGULATIONS

1. The Ward Nurse is responsible for organizing and ensuring the consistency and continuity of Ward Government.

2. The Ward Government meeting shall convene on a monthly basis and involve as many of the patients as possible.

3. Staff shall be available to guide and assist in maintaining the process, and shall respond to questions and help in the resolutions of problems. (Problems not resolved may be carried forward to the next meeting or referred to appropriate personnel for response or action.)

4. Participating patients will select officers--chairman, vice chairman and secretary.

5. The chairman will preside at the meeting (vice chairman in absence of chairman), and the secretary will make a written record of the topics, discussions, actions and assignments. A copy of this record will be sent to the Unit Nurse Coordinator.

6. The Ward Nurse will review the record of the meeting to assist in resolving issues, making sure unresolved issues are carried forward or referred to the Human Rights Committee or other appropriate person(s). In the larger treatment units, a Patient Council is suggested at the unit level.

7. A Patient Council may be formed to condense problems and resolve at a unit level. The Unit Coordinator shall meet and preside at the Patient Council.

8. The chairmen of the Ward Governments may serve on the Human Rights Committee or the patients may select a representative.

9. A committee composed of chairmen will meet on a regular basis with the Superinterdent to form the patient representatives on the Human Rights Committee.

GRIEVANCE MECHANISM FOR THE PATIENT

Individual grievances will be received and reviewed according to Larned State Hospital Policy and Procedure #4.9904 and State Security Hospital Policy and Procedure ~~#VI-16.~~ #6.13. (See attached policies)

APPROVED BY: Hildreth Hultine DATE: 12-10-79
Hildreth Hultine, Superintendent

No. 4.9904

LARNED STATE HOSPITAL

POLICY

SUBJECT: Patients' Grievance Mechanism

EFFECTIVE DATE: July 9, 1979

PURPOSE

To provide that any Larned State Hospital patient* may present written grievances by a simple and orderly system.

POLICY

Larned State Hospital will provide the patient a safe and satisfactory means of expressing a grievance, in writing, for consideration by administration; thereby assuring a prompt and fair settlement.

* The term, patient, would also include students from YRC and clients from Voc. Rehab. Any patient is entitled to utilize this process, regardless of age or disability.

APPROVED BY: Hildreth Hultine DATE: July 5, 1979

Hildreth Hultine, Superintendent

LARNED STATE HOSPITAL

PROCEDURE

SUBJECT: Patients' Grievance Mechanism

EFFECTIVE DATE: July 9, 1979

PARTICIPANTS:

PATIENT (GRIEVANT)
WARD CHARGE AIDE
TREATMENT TEAM LEADER (OR DESIGNEE)
TREATMENT QUALITY AUDITOR
UNIT DIRECTOR
SUPERINTENDENT

RESPONSIBILITY	ACTION
STEP I	
PATIENT (GRIEVANT)	1. Voices complaint to Ward Charge Aide. 2. Writes grievance in simple form, dating it and affixing signatures (unless complaint has been resolved to the patient's satisfaction). 3. Submits written grievance to a staff member.
WARD CHARGE AIDE	1. Receives complaint from patient and evaluates validity. 2. Notifies Treatment Team Leader of receipt of complaint.
TREATMENT TEAM LEADER (OR DESIGNEE)	1. Receives notification from Ward Charge Aide. 2. Confers with patient; resolving problem, if possible; or assists in reducing the complaint to written form. 3. Notifies Unit Director and Treatment Quality Auditor that a written grievance has been prepared. 4. Arranges appropriate meetings to obtain resolution of grievance. 5. Submits grievance and report to Unit Director. (If not resolved in Action 4, above.)
TREATMENT QUALITY AUDITOR	1. Receives information from treatment team leader concerning written grievance. 2. Responds to needs of patient, records actions and submits reports as indicated.

(Step I should be accomplished within two working days.)

Patients' Grievance Mechanism cont.

STEP I

UNIT DIRECTOR

1. Receives grievance and information from treatment team leader, if it has not been resolved in Step I.
2. Interviews patient to attempt a resolution of the grievance.
3. Arranges meetings and/or hearing (if no resolution is obtained); involving patient, Treatment Quality Auditor, Treatment Team Leader, and others as indicated.
4. Sends grievance and report to Superintendent if grievance is not satisfied.

(Step II, time limit, two working days.)

STEP III

SUPERINTENDENT

1. Receives grievance and reports from Unit Director and the Treatment Quality Auditor.
2. Arranges meetings or hearings as needed.
3. Provides written record of decision; giving original to the patient, and sending copy to Unit Director to be filed.

* The written grievance and the records of subsequent action will not become a part of the patient's record, but will be stamped confidential, and filed in the Unit Director's Office.

PATIENTS' GRIEVANCE FORM

No. _____

NAME _____ WARD _____ DATE _____

PATIENTS' COMPLAINT OR GRIEVANCE _____

Rec'd by _____ DATE _____
WARD CHARGE AIDE

Rec'd by _____ DATE _____
TREATMENT TEAM LEADER

Rec'd by _____ DATE _____
DIRECTOR OF S.S.H. OR UNIT ADMINISTRATOR

Rec'd by _____ DATE _____
SUPERINTENDENT OF S.S.H. AND L.S.H.

FINAL DISPOSITION OF CASE _____

TREATMENT TEAM LEADER DATE

DIRECTOR OF S.S.H. OR UNIT ADMIN. DATE

PATIENT REPRESENTATIVE DATE

SUPERINTENDENT OF S.S.H. AND L.S.H. DATE

STATE SECURITY HOSPITAL

POLICY

No. 6.13

SUBJECT: Patients' Grievance Mechanism

EFFECTIVE DATE: March 15, 1979

PURPOSE

To provide that any State Security patient may present written grievances by a simple and orderly system.

POLICY

State Security Hospital wishes to allow to the patient a safe and satisfactory means of expressing a grievance, in writing, for consideration by administration; thereby assuring a prompt and fair settlement.

Vernon Reese, R.N.

Vernon Reese, R.N., Unit Coordinator

Paul Lee, R.N.

Paul Lee, R.N., Unit Coordinator

Date: January 1, 1980

Revised

Procedure: Patients' Grievance Mechanism...Continued -

Step II
Unit Coordinator

1. Receives grievance and information from Treatment Team Leader, if it has not been resolved in Step 1.
2. Interviews patient to attempt a resolution of the grievance.
3. Arranges meetings and/or hearing (if no resolution is obtained); with Treatment Team Leader and others as indicated.
4. Sends grievance and report to Superintendent if grievance is not satisfied.

Step II, Time Limit, Two Working Days

Step III
Superintendent

1. Receives grievance and reports from Unit Coordinator.
2. Arranges meetings or hearings as needed.
3. Provides written record of decision for the patient, giving copies to the Treatment Team leader and Unit Coordinator.

The written grievance and the records of subsequent action will not become a part of the patient's record.

PROCEDURE

SUBJECT: Patients' Grievance Mechanism

EFFECTIVE DATE: March 15, 1979

PARTICIPANTS	Patient (Grievant) Ward Charge Aide Treatment Team Leader (or designee) Unit Coordinator Superintendent

RESPONSIBILITY	ACTION
Step I Patient (Grievant)	1. Voices complaint to Ward Charge Aide.
	2. Writes grievance in simple form, dating it and affixing signature; unless complaint is resolved to patient's satisfaction.
Ward Charge Aide	1. Receives complaint from patient and evaluates validity.
	2. Notifies Treatment Team Leader of receipt of complaint.
Treatment Team Leader (or designee)	1. Receives notification from Ward Charge Aide.
	2. Confers with patient; resolving problem, if possible; or assists in reducting complaint to written form.
	3. Notifies Unit Coordinator that a written grievance has been formulated.
	4. Arranges appropriate meetings to obtain resolution of grievance.
	5. Submits grievance and report to Unit Coordinator, if not resolved by Action #4.

(STEP I SHOULD BE ACCOMPLISHED WITHIN TWO WORKING DAYS.)

PATIENTS' GRIEVANCE FORM

Attachment No. ____

NAME _____ WARD _____ DATE _____

PATIENTS' COMPLAINT OR GRIEVANCE _____

Rec'd by _____ DATE _____
WARD CHARGE AIDE

Rec'd by _____ DATE _____
TREATMENT TEAM LEADER

Rec'd by _____ DATE _____
UNIT COORDINATOR

Rec'd by _____ DATE _____
SUPERINTENDENT OF S.S.H. AND L.S.H.

FINAL DISPOSITION OF CASE _____

_____ _____
TREATMENT TEAM LEADER Date UNIT COORDINATOR Date

_____
SUPERINTENDENT OF SSH & LSH Date

STATE OF KANSAS
ROBERT F. BENNETT, *Governor*

STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
State Office Building
TOPEKA, KANSAS 66612
ROBERT C. HARDER, *Secretary*

December 29, 1976

Division of Vocational Rehabilitation

Division of Social Services

Division of Mental Health and Retardation

Division of Children and Youth

Division of Administrative Services

Alcohol and Drug Abuse Section

State Office Economic Opportunity

The Honorable Robert Bennett
Governor of Kansas
Statehouse
Topeka, Kansas

Dear Governor Bennett:

SUBJECT: Floyd Sappington, Superintendent, Youth Center at Atchison

As you are aware, a decision to make a change in the superintendent at Atchison has been considered for some time. I should like to review briefly for you some of the recent problems which the Department has had.

During late summer the Division of Mental Health and Retardation Services became aware of some problems with the staff at the youth center and concern was expressed that the program for the students at the center was lacking in a number of areas. It became apparent there was difficulty in communication between the Superintendent and the Program Director. Dr. Haines and Mr. Keller had these two men come in regularly to Topeka to meet with them and to attempt to have them work together.

An attempt was made to separate, at least for a short time, the administrative duties at the center from the duties of the Program Director. Mr. Sappington has been Superintendent for a number of years as the institution's functions have changed. Many years ago it was a receiving home, which for some children was an orphans home. The Board of Social Welfare, a number of years ago, decided the children should be placed in homes in the community and such placements were made. A few beds were kept at the institution for short-term evaluations of children who were involved in crisis situations at home or in the community.

The Legislature appropriated funds to establish a youth center program at Atchison and so, the center has had two programs recently, one for juvenile offenders, the other for short-term evaluations.

We attempted to point out to Mr. Sappington that we wished to make maximum use of his management abilities and asked that he take care of the administrative duties of the whole institution and to have the Program Director work with the programs for the children. Such an arrangement would be no different from that at the other youth centers and other institutions. We pointed out to Mr. Sappington that since he would be retiring in about a year and a half, we would like to develop other leadership at the youth center.

At the meetings held in Topeka, it became evident that cooperation was not developing and the men seemed to be in a position to find fault with each other. Each thought the other was not supporting efforts to develop a good program for the children. Since this appeared not to be working to any one's advantage, Dr. Haines visited the institution on December 1, and revoked the split in assignments and announced that Mr. Sappington, being the Superintendent, would be in charge and that Mr. Miller would work with him for the good of the program. This was done to put the full weight of the problem back with Mr. Sappington. If it did not go well, action would be taken against Mr. Sappington.

As mentioned before, there have been a number of complaints and the Department did receive a complaint of child abuse. A team was sent to Atchison and they reported that they did not find evidence of child abuse in the particular case, but as they checked records of individual students they did not find record of specific programs outlined for the student nor of proper progress notes concerning the students. As the team members interviewed employees throughout the institution, it became evident that friction did exist between the Program Director and Superintendent and that it was evident to a number of people that Mr. Sappington attempted to keep close control over all activities.

It seems impossible to have any forward movement in the program. The continued distrust between the Superintendent and the Program Director has allowed staff morale to sink to a level which is detrimental to the entire organization. If we are to move ahead, we feel it necessary to relieve Mr. Sappington of his duties and to relieve Mr. Miller of his duties as Program Director. Since Mr. Sappington is nearing the time of his retirement, he may be convinced to attempt retirement at this time. We will have available a position for a Psychologist at the Osawatomie State Hospital should he wish to continue in state employment until he can retire.

The Department is greatly concerned about this matter and regrets having to take such action but an increasing number of individuals are becoming involved including some Legislators who are not from the district in which the center is located. I should like to suggest the following schedule:

1. To relieve Mr. Sappington of his duties as Superintendent and, if he so wishes, to accept him as a Psychologist on the staff of Osawatomie State Hospital.

2. Make an effort to recruit a qualified individual for the position, including interviews by the Department and Mr. Lawrence Penny, Superintendent of the Youth Center at Topeka.

3. Appoint Mr. Kenneth G. Keller as Acting Superintendent until a qualified individual can be selected.

4. Involve Mr. Penny from the Youth Center at Topeka as a consultant to Mr. Keller and the staff at Atchison during this interim period.

5. To relieve Mr. Miller of the duties as Program Director and appoint Mr. Philip D. Knapp, Psychologist I, as Program Director at the youth center.

I send this letter to you for your information and ask for clearance to have Dr. Haines talk to Mr. Sappington on Monday, January 3. We could give him an opportunity to resign, retire and grant him four to six weeks to move from his house on the grounds at the institution. This would permit him time to announce to his staff his decision. If he does not wish to do this, we would then announce that he is being relieved of his duties.

If you have any questions, please let me hear from you.

Sincerely,

Robert C. Harder
Secretary

Attachment H

STATE OF KANSAS

SOCIAL AND REHABILITATION SERVICES
State Office Bldg.
TOPEKA, KANSAS 66612
ROBERT C. HARDER, Secy.

Youth Center at Topeka

1440 N.W. Highway K-172
Topeka, Kansas 66608

Gene P. Wilson, Superintendent

January 22, 1980

Youth Center at Topeka
Community Advisory Committee

Dear Friends:

Our first meeting of the Youth Center at Topeka "Community Advisory Committee" will be held Thursday, January 24, 1980, at 7:00 p.m. on the YCAT campus in the main building.

GENERAL INFORMATION

The Youth Center at Topeka is located on Highway K-172 in North Topeka. Highway K-172 is a small highway that starts at U.S. Hwy. 24 West and Rochester Road. It runs parallel with 24 highway, going west. Please enter the main entrance (right turn), park in front of the main building (immediately behind the flag pole), and we will meet you.

Although the meetings will be conducted with a format, agenda, etc., we desire a relaxed atmosphere. Please dress as you choose - informal, casual or whatever.

AGENDA

I Introduction of Committee Members and YCAT Staff.
II Short review of the purposes, objectives and functions of the Community Advisory Committee
III Introductory Comments by YCAT Executive Committee
  A. Superintendent, Gene Wilson
  B. Acting Clinical Director, Dr. Jane Warren
  C. Business Manager, John Tilghman

BREAK

IV Orientation - History and organization of the Youth Center at Topeka and formerly the Boys Industrial School (BIS) presented by Mr. Bob Heintzelman, Director of Research and In-Service Training.
V Advisory Committee questions - comments, etc.
VI Agenda for next meeting - March 20, 1980
VII Adjournment - 9:00 p.m.

Sincerely

Gene P. Wilson
Superintendent

Rolland L. Nelson
Chairman

Enc: Copy of YCAT Community Advisory Committee Policy

COMMUNITY ADVISORY COMMITTEE

YOUTH CENTER AT TOPEKA
1440 N.W. Hwy. K-172
Topeka, Kansas 66608

PURPOSE: A Community Advisory Committee will be established to provide for outside resources to understand our programs and to create and encourage greater awareness and support of the Youth Center at Topeka.

OBJECTIVES:

1. To present and expose Youth Center programs to the community.
2. To present new programs that are in the developmental stages to the committee for their examination.
3. To understand the Youth Center programs and relay the information received to other individuals and organizations - public relations.
4. To receive from the Committee, suggestions for improvement in present and future programs and services to the students and community.

FUNCTIONS:

1. To serve as a liaison between the Youth Center and Community.
2. To review programs, policies, procedures and services, which affect the student, the Youth Center and Community.
3. To stimulate public interest and education to the community. (Speakers available from YCAT speakers bureau)
4. To serve as an independent review board of the Youth Center's programs, procedures, services and policies.

Youth Center orients panel to objectives

Officials of the Youth Center at Topeka oriented members of its new Community Advisory Committee in a meeting Thursday night.

YCAT wanted to acquaint various representatives of law enforcement, business, religious and community organizations with the history and objectives of the center.

Rolland L. Nelson, activites director and chairman of the committee, said the group was established to serve as a liason between YCAT and the community and to help review all types of programs there.

Attending the meeting on behalf of their organizations were: Capt. Don Murphy of the Topeka Police Department; Ralph Kingman of the North Topeka Kiwanis Club; Gordon Myers, president of the Sunrise Optimist Club; Bob Price of the North Topeka Businessmens' Association; Richard Campbell, president of North Plaza State Bank; Mrs. Terry Burton of the Seaman Boosters Club; Rick Dalton, managing editor of The Capital-Journal; and Rick Rosen of Unified School District 501.

Officials said several people who were invited to the organizational meeting were unable to attend. Many have said, however, that they plan to attend or send representatives to future meetings.

COMMUNITY ADVISORY COMMITTEE
JANUARY 24, 1980

Rollie Nelson, Chairman and Director of Recreation, introduced the Youth Center Staff: Barbara Wiley, Personnel Director; Milton Jackson, Director of Youth Services; Carol Matern, Secretary; Dr. Jane Warren, Acting Clinical Director; John Tilghman, Business Manager; Bob Heintzelman, Director of Research and In-Service Training and Gene P. Wilson, Superintendent.

Those from the community were Captain Don Murphy of the Topeka Police Department,; Ralph Kingman of the North Topeka Kiwanis Club; Gordon Myers, President of the Sunrise Optimist Club; Bob Price of the North Topeka Businessmen's Association; Richard Campbell, President of the North Plaza State Bank; Mrs. Terry Burton of the Seaman Boosters Club, Rick Dalton, managing editor of the Capital-Journal and Rick Rosen of Unified School District 501.

Gene P. Wilson, Superintendent, who has been here for 21 years greeted the gathering by stating we are excited about this committee and have talked about such a group for many years. He proceeded to give an overview of the institution saying our grounds consist of 333 acres and the main campus has 66 acres. The State Juvenile Code says the boys will be committed to the Secretary of SRS and be placed in institutions from the ages of 13 to 18 years old. We generally admit 15½ to 17 year olds here. On July 1, 1977, the Youth Center at Atchison became an institution for delinquent boys for ages 13 to 15½. We are under one administrative head. The Atchison campus is approximately 50 miles north of here. Boys are adjudicated miscreant or delinquent (having committed a misdemeanor or a felony). There are Youth Centers at Topeka, Atchison, Beloit (for the girls), Osawatomie State Hospital Youth Rehabilitation Center and Larned State Hospital Youth Rehabilitation Center for the older youth. Judges commit to the Secretary for placement rather than to the institution.

Most commitments are from our large counties of Wyandotte, Sedgwick, Reno, Shawnee and Johnson. Our rated bed capacity here in Topeka is 224. Today there were 200 boys on campus. The Governor said in his message he expects our institutions for delinquents to operate near capacity. In no way do we want to place a lot of kids in these institutions, but, budgetwise we should not run an institution below capacity. The bed capacity at Atchison is 112. Last week they had 104 on campus.

Q. Who is the Secretary and does he make the assignments?

A. Dr. Robert Harder is the Secretary. He delegates the responsibility to actually place students in the institutions. Dale Jirik and Jim Trast review cases and place boys in appropriate placements.

Q. Is the difference between Atchison and Topeka strictly on age?

A. Yes.

Dr. Jane Warren, Acting Clinical Director.

One of the main fallacies about our institution is that we are a prison. We don't operate that way. Visitors are surprised with the flexibility and broadness of the program. Cottages hold 15 - 24 students. Boys are called students. We have a very strong clinical program and see ourselves as a rehabilitation agency and not a warehouse.

There are three emphasis:

1. Education. We are part of the Seaman District and have accredited academic and vocational classes plus the GED that is offered. Many students come in with extreme deficits -- 2nd and 3rd grade reading levels. Most of our teachers are PSA teachers, and classes are remedial.
2. Thearapeutic: We have 11 social workers, 7 psychologists, 2 psychiatrists, a chaplain, music therapist, recreation. The Youth Service Workers operate the cottages and we also have P.E. with varsity football, basketball and track.
3. Vocational Program -- classes include auto mechanics, machine shop, welding, print shop and the carpentry shop. We have a good relationship with Vo Tec where the students can go on in their chosen trade.

The average student stays approximately 11 months. Some students stay much longer. The big problem is where to place some of them. Community resources vary from community to community. If a student comes from a home where there are problems it is difficult to send him back. Recently Topeka has developed a half-way house program and we have placed some students there and Wyandotte has developed a follow-up program.

Q. Do they go to school 12 months?

A. Yes - 8:00 a.m. to 3:30. Even in our closed units they have the classroom there. All of our teachers are trained to work with emotionally disturbed children. We do testing before and after. The 12 month program allows the boys to catch up with his current grade placement.

Q. For those boys who can attend school do you place them in Seaman?

A. No. Not any more. A class load here is only 8 - 10 students.

Q. Did I understand that the average stay is only 11 months?

A. One who comes in as a violent offender stays much longer. Also, when there is a family problem or community problem they usually stay longer.

Q. Is it up to you to decide when they can be released?

A. Yes. It is not up to the courts. We have a level system. The boys earn points for good behavior and lose points for bad. Students come to us on an indeterminate sentence. In addition we set special goals they must meet. Some want to stay. This is sometimes the best place they have ever been.

JOHN G. TILGHMAN, Business Administrator. He operates the budget and our kids eat just as well the last day of June as they do the first day of July. He sees that we use the money we have in the best possible way to provide a program for the kids. He must determine what the real needs are. He also supervises the non-clinical areas; Information Center, Dietary, Engineering, and Supply.

Since 1977 we have picked up another campus and now the money comes into one pot rather than two. We have 25 buildings on this campus and 18 at Atchison, for a total of 43. There are 12 cottages here. There are 204 positions here and 114 at Atchison for a total of 318. Youth Service Workers make up the largest department under Milton Jackson's supervision here and Bill Vigola's at Atchison. 5 1/2 million dollars expenditures for FY 1979. Salaries and Wages was 3.6 million. Governor Carlin says there will be no new buildings, you will keep up what you have. We asked for 28 new positions and received only one that had been originally funded on a grant. However, the budget gives us everything we asked for to maintain the buildings. We are to maintain what we have, work with what we have and keep the place full. On both campuses, the cost per day per boy is $54.00 Funds come from State Appropriations, General Revenue,$140 thousand per year from Title I and money from the Federal Government through the School Breakfast and Hot Lunch Program.

Each boy has his own account into which his money is received. We take all the money we can spare and invest it. When interest checks come out each boy gets his proper share. If a child has an income from a retirement fund or something similar, most of that money goes with him when he leaves.

In addition to the 318 positions, 15 positions are funded on contract through Seaman. Before this arrangement our academic school was not certified. There are another 8 on Title I. There are 24 teaching positions, a vocational counselor and a typist. Atchison has the same type of program.

Q. & A. 80 - 85% goes into salaries and wages and into fringes in any business.

BOB HEINTZELMAN, Research and In-Service Training Director. He presented the history and organization of the institution.

In ancient times they used the dungeons. In modern times they use individual programs for individual people.

The school started as an agricultural center with cows, pigs, chickens, etc. , and the emphasis was on hard work. We still have two of the barns on campus.

The second phase was the military school, cottages were then called companies, staff were officers and the emphasis was on hard work and strict discipline.

The third phase was the parent model with the family structure, which unfortunately came along when the cottages had about 50 kids in them.

The fourth era was the peer pressure and/or group dynamics.

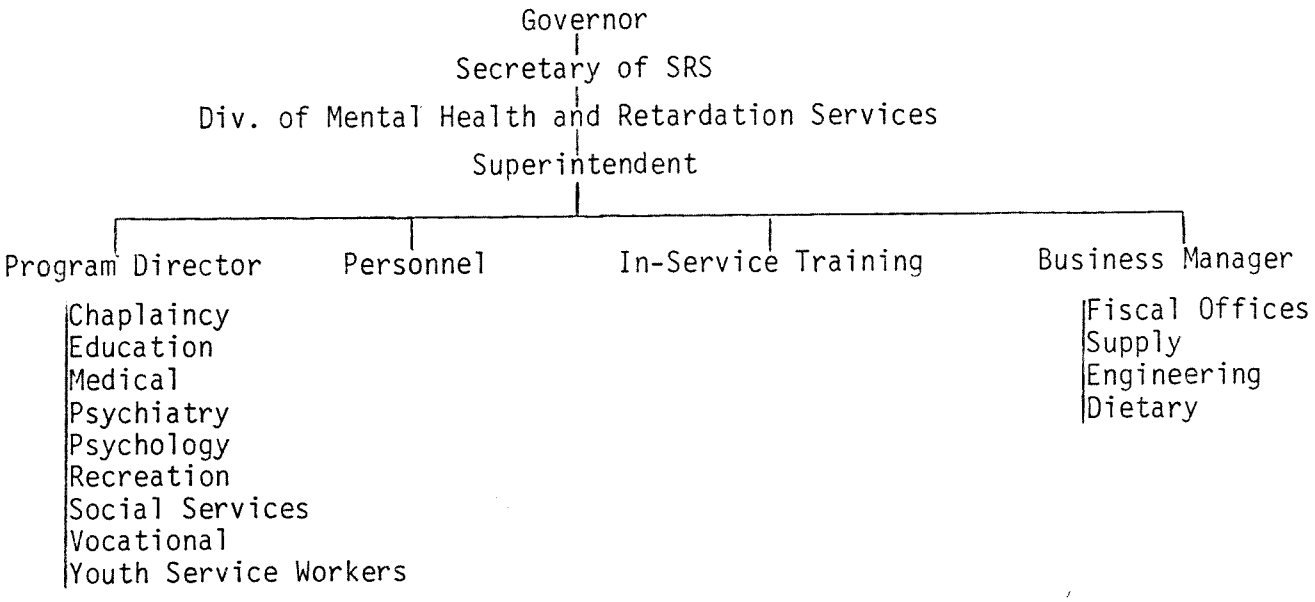
The present mode is emphasizing behavior, learning and consequences.

1879 - The institutional construction began, and it was called the State Reform School.
1881 - The first youth was admitted
1905 - The name was changed to Boys Industrial School
1912 - Military Program
1935 - The first psychologist came on staff.
1938 - Osborn Society condemned the place and this began the turning point.
1941 - State Civil Service came into being - prior to this everyone was appointed and when the governor changed so did everyone else.
1946 - End of Military approach
1947 - First psychiatrist came on staff - Prior routine was hard work - Kids didn't talk unless they were given permission. Treatment meant finding out about them as people.

1950 - Group psychotherapy program
1952 - Racially desegregated
1954 - Cottage committee system was set up
1967 - School became a part of Seaman USD #345
1973 - Level system came into being
1974 - the name was changed to Youth Center at Topeka
1976 - The Point system was implemented
1979 - Change from cottage parents to Youth Service Workers with a career ladder for these people.
1980 - Community Advisory Committee formed.

When the school was an "industrial" school we sold and made a profit for the state. It was a work farm and the superintendent had to show a profit.

Present Organizational Chart:



We come under SRS because our kids are handicapped, not necessarily physically, but mentally, and it can be fatal. We provide services in all life areas for any problems the kids may have; physical, learning, psychological or family.

The cottage committee consists of the coordinator (usually a psychologist) who is the decision maker. Then there is the social worker and the cottage director. These people design and carry out a total program for the kids. Each youth is treated as an individual.

QUESTIONS AND ANSWERS:

Q. How much money are the kids allowed?

A. Some kids do not have an income and the state provides $1.50 per week spending money. More than 1/4 are indigent. Others are allowed $2.00 per week to spend at the canteen. They can check out other money to go to town to go shopping. We try to give them some experience in buying. Money is limited. Drugs and alcohol are then not a problem as we have a tight rein on the boys' money. No one is trying to peddle drugs here

as there is no market, and no one wants to take the chance of getting caught with these kids. Some is of course brought in when they go on pass or someone brings in a cigarette, but it is always small amounts. What little they do get is not a problem.

Rollie Nelson, who operates the canteen, gets 90% of the money. Most parents bring cigarettes (parents supply approximately 80%)

Q. What feedback do you get from parents?
A. Certain percent that you can't do anything right. Some of the problems the youth carry in are the ones they have had in the homes.

Meeting adjourned

Carol M. Matern
Secretary

Attachment I

STATE OF KANSAS
JOHN CARLIN, GOVERNOR

SOCIAL & REHABILITATION SERVICES
STATE OFFICE BUILDING
TOPEKA, KANSAS 66612
ROBERT C. HARDER, SECRETARY

OSAWATOMIE STATE HOSPITAL
OSAWATOMIE, KANSAS 66064
J. RUSSELL MILLS, SUPERINTENDENT
(913) 755-3151

February 1, 1980

The Honorable Robert A. Coldsnow
Legal Counsel to the Legislature
Room 449-N
State House
Topeka, Kansas 66612

Dear Mr. Coldsnow:

I wish to invite the 1980 Special Study Committee on Social and Rehabilitative Institutions to meet at this hospital to receive testimony from patients and employees concerning the management structure and utilization of personnel of the Osawatomie State Hospital. All members of the staff at all levels have been informed that they are free to testify before the committee without thought of recriminations.

As superintendent of one of the institutions which is receiving considerable amount of adverse publicity, I wish to request the opportunity to testify before the committee. I will be available at any time convenient to the committee to respond to allegations concerning misconduct of patients and staff as well as mis-management of the hospital. I look forward to hearing from you at an early date.

Respectfully,

J. Russell Mills

J. Russell Mills
Superintendent

JRM:gm

cc:
Dr. Harder
Mr. Keller